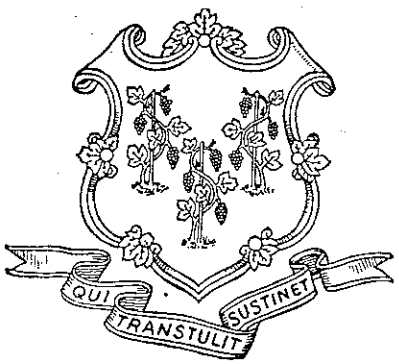
SERVICES FOR THE ELDERLY TO SUPPORT DAILY LIVING

Connecticut

General Assembly



LEGISLATIVE
PROGRAM REVIEW
AND
INVESTIGATIONS
COMMITTEE

December 1996

CONNECTICUT GENERAL ASSEMBLY
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and during the 1977 session added responsibility for "sunset" (automatic program termination) performance reviews. The committee was given authority to raise and report bills in 1985.

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LEGISLATIVE PROGRAM REVIEW
& INVESTIGATIONS COMMITTEE

Services to the Elderly to Support Daily Living

DECEMBER 1996

Table of Contents

SERVICES FOR THE ELDERLY TO SUPPORT DAILY LIVING

Table of Contents

Introduction

SERVICES FOR THE ELDERLY TO SUPPORT DAILY LIVING

The Legislative Program Review and Investigations Committee voted to conduct a study of Services for the Elderly to Support Daily Living in February 1996. The committee's primary concern was evaluating whether enhancing home health care services would improve services to the elderly and reduce institutional costs. In addition, the committee was interested in examining the array of care and types of services provided to elderly persons in need of assistance because of frail health, as well as the need for and availability of these services.

Study focus. This report identifies the array of long-term care programs and services provided to frail elderly persons over 65 years old. The focus of this study is on the Connecticut Home Care Program for Elders (CHCP), the primary vehicle used by the state to provide home and community-based services to frail elderly and prevent their institutionalization in nursing facilities. Although an intensive review of long-term care services provided in nursing facilities was not part of the study scope, the program review committee did include a profile of nursing home facilities and a description of the clients residing in them. In addition, the array of other supportive housing options available to elderly persons who need assistance with daily living is presented.

Information on the settings in which frail elderly receive services is presented in order to provide a comprehensive picture of the existing long-term care system. This report presents a description of the intake process and eligibility criteria used to obtain long-term care services, the assessment process to determine the level of need and most appropriate setting to deliver services, the number of elderly persons using services, and the types of services provided. The resources expended in the provision of these services are also identified.

Exclusions. Specifically excluded from the scope of study was any description of long-term care services provided to persons under 65 years old. In addition, analysis of long-term care services, including home health care services provided to elderly persons through the Medicare program, was also excluded. Finally, home health care services provided for acute and episodic illnesses were not included in this review.

Methodology. A variety of sources and research methods were

used in conducting the study of Services for the Elderly to Support Daily Living. Committee staff interviewed a number of individuals in the Department of Social Services (DSS), the administering agency, as well as Access Agency care managers, industry representatives, providers, and advocates. In addition, committee staff visited several homes and apartments with providers in order to observe the delivery of services to CHCP clients.

A wide range of articles, reports, and other published materials relating to long-term care for elders was also reviewed. Federal and state statutes, state budget documents, reports issued on the program by DSS and various cost and client data were examined. Finally, a survey of hospital discharge planners was conducted by the committee to obtain information on awareness of the CHCP and the need for long-term care services in general.

Report organization. This report contains eight chapters. The first defines long-term care and provides a brief summary of the long-term care delivery system used by individuals who need services. In addition, other major initiatives occurring within the legislature and the Department of Social Services that will impact the long-term care system are described. Chapter Two is an overview of the federal programs used to fund the long-term care system. Chapters Three and Four provide a description of the CHCP, information on the frail elderly served by the program, and an analysis of program expenditures and cost-effectiveness. Chapter Five contains information on supportive housing arrangements as well as a description of the services provided in nursing facilities and on the clients who reside in those facilities. An examination of the costs associated with service delivery in each of these settings is also provided. Chapter Six reviews the current demographics nationally and in Connecticut of persons over 65 years old, provides projections of the population over the next several decades, and discusses the potential demand for long-term care services by the frail elderly. Chapter Seven presents findings from the committee's survey of hospital discharge staff. Finally, Chapter Eight contains the committee's findings and recommendations. In addition there are nine appendices.

It is the policy of the Legislative Program Review and Investigations Committee to provide state agencies subject to a study with the opportunity to review and comment on the recommendations prior to the publication of the final report. A copy of the Department of Social Services' response in contained in Appendix A.

KEY POINTS

CHAPTER ONE: DEFINING LONG-TERM CARE

- Long-term care is defined as a wide range of medical, social, personal care, and supportive services needed by individuals who, because of a chronic illness or condition, have lost some capacity for self-care and need assistance with daily activities for an extended period of time.

- There are three major components of the long-term care system: home and community-based services; supportive housing arrangements; and care provided in nursing facilities.

- The majority of public funds used for long-term care pay for care delivered in nursing homes and to a much lesser extent for home and community-based care. There has been extremely limited use of public funds to pay for supportive housing arrangements.

- In FY 95 long-term care provided in nursing homes consumed more than 8 percent of the total General Fund state budget of $9.8 billion; while services delivered through the Connecticut Home Care Program (CHCP) consumed less than 1 percent.

- Over $802 million was expended on care provided in nursing facilities in FY 95, while only $67.3 million was expended on home and community-based care provided through CHCP.

- Clients enter the long-term care system by having their need for long-term care assessed. The goal of the assessment process is to determine an individual's level of need and then identify the most appropriate setting for service delivery.

- Key assessment criteria include: inability to perform certain functions or activities; the type of illness and medical supervision needed; the availability of family support; client safety issues; client choice; and cost of services needed.

- Informal care provided by family members plays a major role in maintaining frail elderly in the community.

- Three separate efforts are occurring within the state that examine the needs of the frail elderly: development of a Medicaid waiver; a task force on nursing home issues; and a task force on congregate housing.

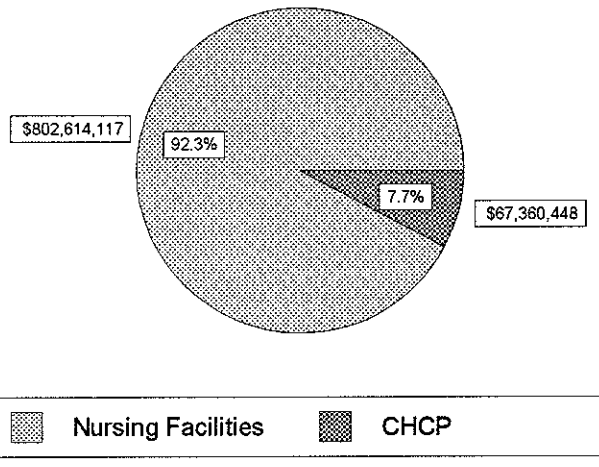
Chapter One

DEFINING LONG-TERM CARE

The goals of designing a comprehensive long-term care system are aimed at controlling costs and helping people remain independent in their home and community for as long as possible. Today, the need for long-term care services, particularly home and community-based services, is based on a variety of reasons. The role of women as traditional providers of home care to relatives has decreased since many are now in the workforce. In addition, their is greater mobility of family members making it less likely for them to care for an aging parent. Also, many elderly individuals may have outlived their spouses or the spouse providing care may also be in need of services.

Currently in Connecticut the majority of resources dedicated to providing long-term care services are used to pay for institutional care rather than provide home and community-based services. Long-term care services provided to the elderly in nursing facilities consumed over 8 percent of the total state General Fund budget in FY 95. As shown in Figure I-1, over $802.6 million (including Medicaid matching funds of 50 percent) was expended on care provided in chronic and convalescent nursing homes (CCHNs) or rest homes with nursing supervision (RHNS) in FY 95. By comparison, $67.3 million (including $28.2 million federal Medicaid funds) was spent on services delivered through the Connecticut Home Care Program for Elders. In contrast, the CHCP consumed less than 1 percent (.68 percent) of the state General Fund budget of $9.8 billion for FY 95.

Figure I-1. LTC Expenditures in CT
FY 95



Source: LPR&IC Analysis.

Defining Long-Term Care. Although there is not a single universally accepted definition of long-term care, those reviewed by the program review committee encompassed certain basic elements. While the phrase long-term care is usually used in connection with nursing homes in Connecticut, it really has a much broader definition. Long-term care generally refers to a wide range of medical, social, personal care, and supportive services needed by individuals who, because of a chronic illness or condition, have lost some capacity for self-care and need assistance with daily activities for an extended period of time. Most of the support needed is not complex medical care, but assistance from others with the routines of daily living.[1] Long-term care services can be provided in institutions such as nursing homes, in supportive housing arrangements, or in home and community-based settings to persons of any age or income. However, this study concentrates on persons aged 65 and older.

Point of system entry. A key element in examining long-term care lies in understanding how clients enter the system. An individual's need for long-term care is usually measured by assessing limitations in his or her capacity to perform certain functions or activities. These measures are called *activities of daily living (ADLs)* and include such actions as bathing and dressing. Another set of activity limitations that reflects lower levels of disability include difficulties in performing household chores and social tasks. These are called instrumental activities of daily living (IADLs). IADL measures are used because the types of tasks an individual must perform, such as managing money, can be more complex than some of the ADLs such as eating.

Table I-1 provides a definition of the measures used in assessing limitations and functional independence. The level of cognitive functioning and the behavioral status are also important indicators in the assessment process. Together, these measures are used when determining if an individual needs long-term care services and if so, the appropriate level of service needed.

There are several factors considered in assessing the need for long-term care services; the goal being to determine the level of need of an individual -- typically based on the frequency and intensity of support services, and then identifying the most appropriate setting for service delivery. In addition to assessing an individual's ADL, IADL and cognitive status, other key criteria used in the assessment process include:

- the type of illness and medical supervision needed;
- the availability of family support;
- client safety issues;
- client choice; and
- cost of services provided.

[1]General Accounting Office, *Long-Term Care: Diverse, Growing Population Includes Millions of Americans of all Ages,* (GAO/HEHS-95-26, November 1994).

Table I-1. Measuring Functional Independence.	
Activities of Daily Living (ADLs)	Measures include getting to and using the bathroom, bathing, dressing, eating, transference (lifting oneself from one place to another, such as a bed to a chair), stair climbing, mobility, walking, wheeling, bowel functioning and bladder control
Instrumental Activities of Daily Living (IADLs)	Measures include managing money, taking medicine, preparing meals, cleaning, grocery shopping, using the telephone, and ability to travel from residence.

Source: LPR&IC, 1996.

Combined, these factors often are critical in determining the delivery system that is most appropriate to provide an individual with long-term care services.

The Long-Term Care Delivery System

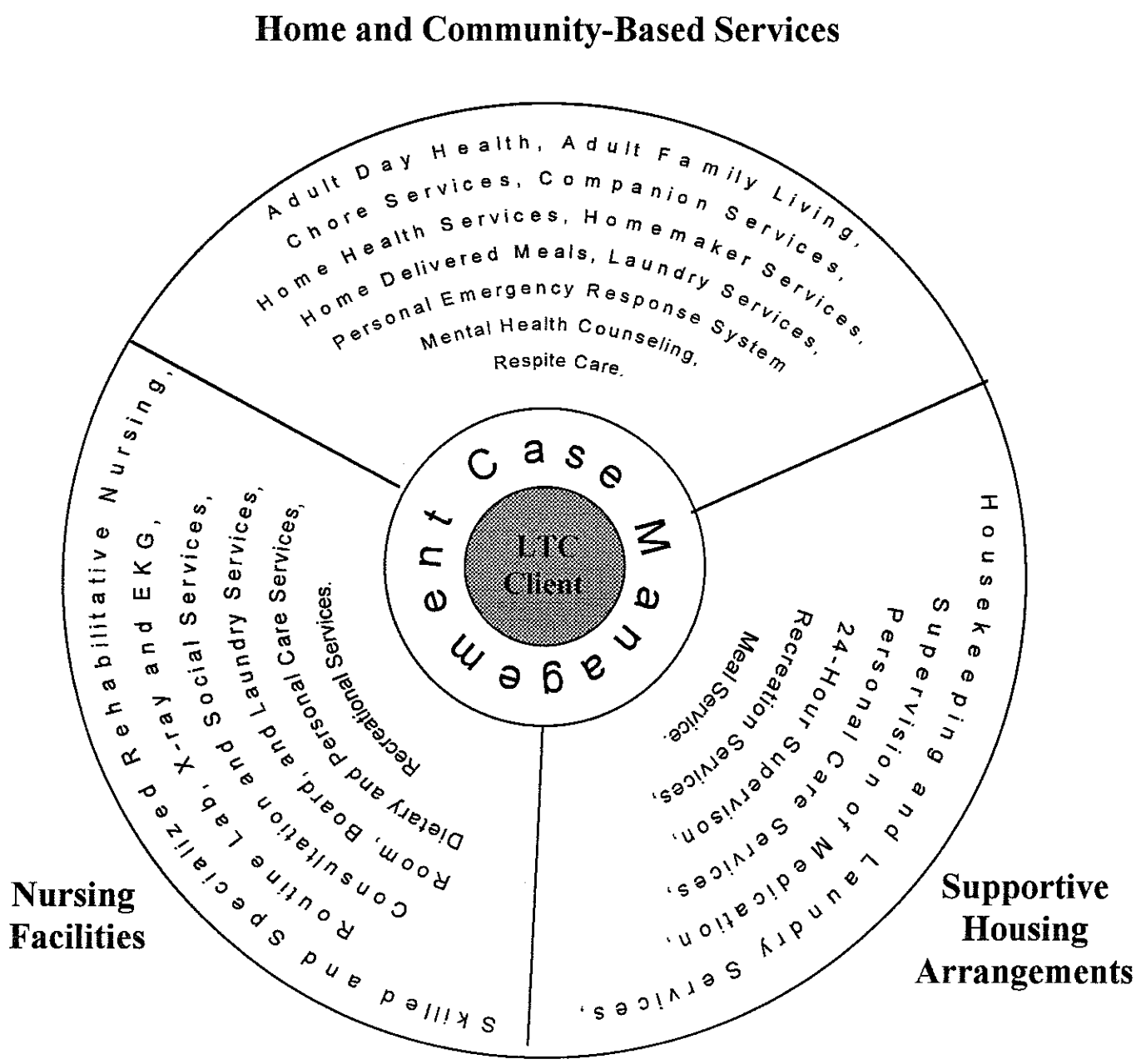
The long-term care system can best be characterized by three major components that surround the elderly client. The three components provide an array of services funded from a variety of sources -- public agencies, private individuals, and insurance entities. Each component of service is tied to a specific housing arrangement. The three components are:

1) home and community-based services;
2) supportive housing arrangements; and
3) nursing services in a residential setting.

Figure I-2 displays the nature of the long-term care system. The majority of public funds have been used to support care delivered in nursing homes and to a much lesser extent for home and community-based care. There has been extremely limited use of public funds to develop programs dedicated to supportive housing arrangements. Funding of each of these options is described in greater detail later in this report.

Home and community-based systems. Home and community-based services for frail elderly persons are publicly funded and available under the Connecticut Home Care Program for Elders. In a home and community-based delivery system, health, personal care, and social services are provided over a sustained period to persons who live in non-institutional settings.

Figure I-2. The Long-Term Care Delivery System



The recipient of services may live in their own home or apartment, with relatives, or in a variety of supported housing settings. A broad range of services is available under CHCP including home health services such as skilled nursing services and home health aides, and community-based services such as adult day health services, chore services, companion services, and home delivered meals.

Services provided under the Connecticut Home Care Program are limited to individuals aged 65 and older who meet financial and functional criteria. In addition, the program places limits on the average cost of the services received. If an individual needs a level of care that exceeds the cost cap, he or she would not be eligible for services under this program. The program is described in greater detail in Chapters Three and Four of this report.

Family support. Care provided by family members plays a major role in maintaining frail elderly persons in the community. Care provided by family and friends is considered informal care, as opposed to formal care provided by paid providers. Informal care is usually not reflected in the cost of long-term care services. National estimates of type of support received by severely disabled elderly persons indicate that 70 percent receive only informal support; 3 percent receive formal support; and the remainder (27 percent) receive a mix of informal and formal support.[2]

Research conducted by the University of Connecticut's Institute for Social Inquiry in 1994 found 14 percent of all Connecticut households were helping to care for an aging relative and the majority of these households (57 percent) reported caring for a parent. Some respondents reported caring for a spouse (9 percent) or another relative (24 percent). Thirty-eight percent of caregivers said the care recipient lived with them, while 62 percent reported the recipient lived in another household. Survey respondents were also asked if they needed additional help in caring for the aging relative with 19 percent saying they did, 72 percent did not, and 9 percent stated they were already receiving additional help.[3] Family support is a critical component in keeping people at home and out of residential care.

Formal supports. There are several factors that increase the use of formal supports among people needing long-term care services. First, as functional impairments increase, the level of formal support also tends to increase. In addition, more women use formal supports than men, partly because of a longer life expectancy. Increasing age also is likely to lead to the use of more formal supports. Finally, persons who live alone and those who have higher incomes also have been shown to use more formal supports.

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[2]Committee on Ways and Means, U.S. House of Representatives, *Overview of Entitlement Programs*, 194 Green Book.

[3]Department of Social Services, *State Plan on Aging*, October 1, 1995 to September 30, 1997.

Feasibility of home care. Although many elders who need long-term care can remain at home and in the community with help, home care services are not a viable option for all elderly persons. In general, use of public funds for home care is not a practical option when:

- the illness or circumstances are too complex and a person needs full-time care;
- the person's condition makes home care more expensive than residential or nursing home care;
- family members are not well enough to care for a person;
- family members are unable to cope (stress); and/or
- there is no family support system or the family is unwilling to be responsible.

Supportive housing arrangements. The next major component of the delivery system is supportive housing arrangements. Supportive housing arrangements serve people who need assistance with long-term care, but do not need intensive nursing services. Elders may move into a supportive housing environment because they lack an informal support system. Supportive models include residential care homes, managed residential facilities with assisted living, continuing care retirement facilities, and congregate housing. Supportive housing arrangements generally would exclude traditional elderly housing which does not require the provision of support services.

The State of Connecticut provides funding for the development of congregate housing and an operating subsidy for congregate activities. Government support for the development of other types of supportive housing, or ongoing rental assistance in these settings, is extremely limited or nonexistent.

Nursing facilities and institutional systems. The level of care provided by nursing home facilities is the most intensive component of the long-term care system. Usually, nursing home care is needed when an individual has a major illness or condition that requires round-the-clock supervision. Care may also be provided when a person has substantial needs based on ADL status and/or cognitive limitations or when there is a lack of family support in providing care. Having insufficient financial resources to pay for home delivered services can also lead to a need for nursing home care. Nursing facilities provide personal care and nursing supervision or skilled nursing care under medical supervision 24 hours per day. Stays in nursing homes can be short- or long-term depending on the health status of the individual.

The Department of Social Services conducts two types of screenings for individuals seeking admission into a nursing home. First, the department is responsible for screening all individuals for evidence of mental retardation or mental illness. Second, the department screens all elderly Medicaid-eligible individuals seeking admission to a nursing facility. Private pay patients enter nursing facilities based upon a physician's documentation of need for nursing home care. Chapter Five describes the admission process and provides expenditure and client demographic information.

Other Connecticut Initiatives

Soaring Medicaid costs, particularly for institutional care for the elderly, have prompted the state to examine how best to integrate the financing and delivery of health and supportive services for the elderly. As new long-term care models emerge, there will be major implications for the home and community based services, supported housing arrangements, and institutional care. As a result, the need for significant policy and program changes will be required in order to respond to the new payment systems.

Managed health care is becoming firmly established as a way in which to contain costs by integrating the financing and delivery of health services. Both the private and public sectors have moved significant numbers of individuals into managed care health plans. Of its Medicaid population, Connecticut required the Aid to Families with Dependent Children (AFDC) and AFDC-related clients to enroll in managed care. Now, as the state looks to more cost-effective arrangements to contain long-term care Medicaid expenditures, enrollment of the elderly into managed care health care is being planned by the Department of Social Services. Currently, there are three separate efforts occurring within the state that will examine the needs of the frail elderly: development of a Medicaid waiver; a task force on nursing home issues; and a task force on congregate housing. Each of these efforts are described below.

Medicaid research and demonstration waiver. The legislature, through the Office of Fiscal Analysis 1995-1997 Budget narrative, directed DSS to develop an 1115(a) Medicaid research and demonstration waiver that would provide managed care for the elderly and disabled. DSS joined with five other New England States and expects to submit a joint waiver request to the Federal Health Care Financing Administration. The intent of the waiver is to develop a system that would integrate primary, acute, and long-term care services to individuals who are eligible for both Medicaid and Medicare benefits, otherwise known as "dually eligible." Services would be delivered through entities designated as "Integrated Service Networks" (ISNs). Currently, these types of entities do not exist in the state.

The waiver would create a system of capitated rates[4] for all medical care for the elderly, including long-term care, home health care, and ancillary services for people who are dually eligible. This would replace the current Medicaid long-term care reimbursement system. In addition, the waiver would be extended to include all Medicaid recipients, including the aged, blind, and disabled.

Public Act 95-257 established a legislative "Waiver Application Development Council" responsible for advising DSS, the lead agency, in developing a 1115 Medicaid waiver. The council includes the chairmen and ranking members of the Appropriations committee and six

[4]Capitation is a set amount of money calculated on a per member per month basis.

legislators. The council must advise DSS concerning:

- the populations to be included in a managed care program;
- the timetable for including distinct populations;
- the expansion of access to care;
- quality assurance; and
- grievance procedures for consumers and providers.

Nursing Home Task Force. The Connecticut General Assembly adopted Public Act 96-245 during the 1996 legislative session which created a 19-member nursing home task force to examine a variety of issues related to nursing homes. The task force's mandate includes reviewing:

- the cost reimbursement system for nursing homes located in distressed communities;
- the present and future demand and supply of nursing home beds including consideration of the current moratorium on building facilities with new nursing home beds;
- the certificate of need process for nursing home facilities and services;
- recoupment of nursing home costs through applied income, asset collection, over payments, and third-party liability;
- competitive bidding of nursing home clients;
- alternative arrangements for nursing home clients;
- the adequacy of nursing home client data; and
- admission procedures for nursing home patients.

The act required the task force to submit a report on its findings and recommendations to the public health committee not later than January 1, 1997.

Congregate Housing Task Force. The 1996 legislative session also created a congregate housing task force to examine congregate housing for the elderly under Public Act 96-245. The task force is composed of 11 members and is charged with reviewing the role of congregate housing in the provision of housing throughout the state, funding mechanisms, the calculation of rent, the level of services to residents in congregate housing, and the role of such housing in the health care delivery system. Recommendations are to be submitted to the housing committee by January 1, 1997.

KEY POINTS

CHAPTER TWO: FEDERAL PROGRAMS SUPPORTING LONG-TERM CARE

- The Medicaid program, jointly funded by the state and the federal government, is the primary payor of long-term care services, and the major public program providing coverage for nursing home care.

- Limited coverage is available under the Medicare program and through private insurance.

- Both federal and state governments continue to devote an increasing share of their budget resources to Medicaid long-term care expenditures.

- Nationally, total Medicaid expenditures for all types of long-term care services increased 35 percent from $33.8 billion in FFY 91 to $45.7 billion in FFY 95.

- Institutional services consumed about 82 percent of Medicaid long-term care expenditures. Of the dollars spent on non-institutional care, only 8.3 percent is spent on home and community-based services provided under a Medicaid waiver which specifically targets frail elderly to prevent their institutionalization.

- To contain Medicaid costs, states have focused on preventing or prolonging movement into institutional care by enhancing the resources expended on care provided in home and community-based settings and in supportive housing arrangements.

- In 1981, Congress adopted a provision that allowed states to receive a Medicaid waiver to correct a bias toward institutional care in Medicaid services for the chronically ill. Under an approved waiver, states may cover a variety of nonmedical, social, and supportive services (in addition to home health services already covered by Medicaid) that are critical in allowing persons to remain in the community.

- The rationale for these waivers was that individuals who would otherwise be institutionalized at the state's expense could be diverted if services were available to support them in the home.

Chapter Two

FEDERAL PROGRAMS SUPPORTING LONG-TERM CARE

Long-term care includes an array of health, personal care, social, and supportive services. The services can be provided either formally through government supported programs that use public funds to pay for services, privately through insurance coverage, or informally, through the use of family and friends who often provide continuing care for frail elderly at little or no cost.

Long-term care services to the elderly are financed through federal, state, and local governments and often involve a complex system of funding and an array of service providers. Although Connecticut offers numerous programs to the elderly, the greatest amount of dollars is consumed by those needing long-term care. The Medicaid program, jointly funded by the state and the federal government, is the primary payor of long-term care services and the major public program providing coverage for nursing home care. Limited coverage is available under the Medicare program and through private insurance. These programs have historically paid for services that are institutional and medical in nature with less resources being applied to home and community-based services. Appendix I provides information on states who have achieved progress toward implementing strong home and community-based delivery systems

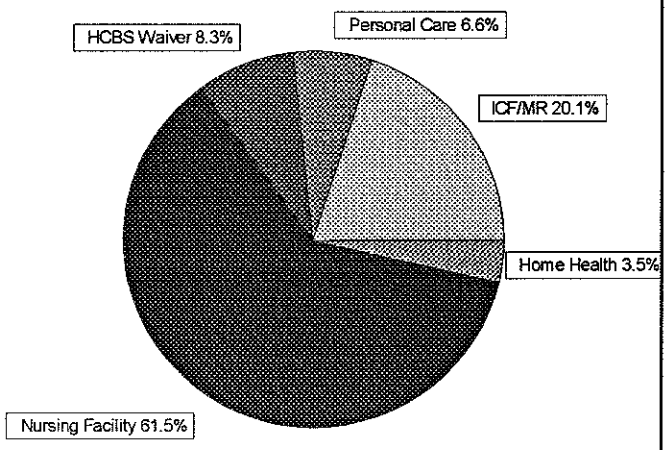
Both federal and state governments continue to devote an increasing share of their budget resources to Medicaid long-term care expenditures. As budget pressures increase, states have begun to adopt new approaches in order to contain long-term care costs. These approaches have focused on preventing or prolonging movement into institutional care by enhancing the resources expended on care provided in home and community-based settings and in supportive housing arrangements. The development of the Medicaid 1115 waiver currently occurring within DSS is an example of the nationwide trend of the transformation in state long-term care policy.

Source of Payment for Long-Term Care

National long-term care expenditures under Medicaid. Nationally, total Medicaid expenditures for all types of long-term care services increased from $33.8 billion in FFY 1991 to $45.7 billion in FFY 1994, a growth of 35 percent. Institutional services consumed about 82 percent of Medicaid long-term care expenditures and home and community-based services, the remaining 18 percent. Figure II-1 provides a breakdown of Medicaid long-term care expenditures in FFY 94.

As shown in the figure, of the dollars spent on non-institutional care, only a small percentage is spent on home and community-based services provided under a Medicaid waiver which specifically targets frail elderly to prevent their institutionalization. Nursing home expenditures accounted for the largest proportion of Medicaid long-term care expenditures -- 61.5 percent -- while home and community-based services available under a Medicaid waiver comprised only 8.3 percent.

Figure II-1. National LTC Medicaid Expenditures 1994



Expenditures= $45.7 Billion.

Federal Long-Term Care Programs. Table II-1 lists the major federal programs providing funding for long-term care services. There are four major programs providing federal funds -- Medicare, Medicaid (and the waiver program), Older American's Act, and the Social Services Block Grant.

As the table shows, the federal government funds a variety of services. Under Medicaid, community-based services, often necessary to prevent institutionalization, may only be provided through a Medicaid waiver. Although no Medicaid waivers are available to reimburse housing costs, such as congregate housing or assisted living; the actual supportive services delivered in these settings may be covered under a Medicaid waiver. Connecticut's waiver allows CHCP services to be delivered to elders in boarding homes, congregate housing, and any other non-institutional setting as long as they are not already included in the room and board charge. It does not provide services in assisted living facilities. A brief description of the long-term care services provided under each of the programs is described below.

Medicare. Medicare, authorized under Title XVIII of the Social Security Act, is a nationwide health insurance program for the aged and certain disabled persons. It consists of two parts: the hospital insurance program (Part A) which covers in-patient hospitalization and limited post-hospital care; and the supplementary medical insurance program (Part B) which covers physician, out-patient care, and other medical services. Most Americans age 65 or older establish eligibility on the basis of employment covered by either the Social Security or railroad retirement systems and are automatically entitled to protection under Part A. Part B of Medicare is voluntary and individuals may elect to enroll in the supplementary medical insurance program by paying the monthly premium.

Table II-1. Major Federal Programs Supporting Elderly Long-Term Care Services.		
Program	***Objectives***	***Long-Term Care Services***
Medicare/Title XVIII of the Social Security Act	To pay for acute medical care for the aged and selected disabled	Home health visits, limited skilled nursing facility care
Medicaid/ Title XIX of the Social Security Act	To pay for medical assistance for certain low-income persons	Nursing home care, home health services and if states elect this option, some community-based services
Medicaid 1915 (c) Waiver	To pay for home and community-based services for frail elderly, mentally retarded, and other disabled and chronically ill persons at risk of institutionalization	Home and community based health and social services targeted to specific Medicaid recipients
Older America's Act/ Title III	Foster the development of a comprehensive and coordinated service system to serve the elderly	Nutrition services, home and community-based social services, protective services, and long-term care ombudsman
Social Services Block Grant/Title XX of the Social Security Act	To assist families and individuals in maintaining self sufficiency and independence	Services provided at the states' discretion, may include long-term care

Source: GAO Report #GAO/T-HEHS-94-140, *Long-Term Care, Demography, Dollars, and Dissatisfaction Drive Reform*, April 12, 1994.

Long-term care services, available on a limited basis under Part A of Medicare, are shown in Table II-2. Payment of nursing home care is limited with coverage provided only following a three day hospital stay. As the table shows, Medicare pays the full cost for the first 20 days of nursing home care. However, for days 21 through 100, recipients of nursing home care are required to pay a $89.50 co-pay. Medicare does not pay for care provided beyond 100 days.

Medicare provides limited coverage for home health visits under certain conditions. Visits are covered only for persons who are homebound, under the care of a physician, and are in need of skilled nursing care on an intermittent basis, or physical or speech therapy. The home health benefit is not subject to deductibles or co-pays.

Table II-2. Medicare Long-Term Care Benefits.			
Services	*Benefit*	*Medicare Pays*	*Recipient Pays*
Posthospital Skilled Nursing Facility Care	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but $89.50/day	Up to $89.50/day
	Beyond 100 days	Nothing	All Costs
Home Health Care Medically Necessary Services and Supplies (covered by Part B if you don't have Part A)	For as long as you meet Medicare requirements for home health care benefits	Services - 100% of approved amount	Services - nothing
		Durable medical equipment - 80% of approved amount	Durable medical equipment - 20 percent of approved amount

Source: Connecticut Partnership for Long-Term Care.

Medicaid. Medicaid, a means-tested entitlement program funded by the federal government and the states, pays for medical services for certain low-income persons. Under a state Medicaid Plan, a state is required to provide home health services for any individual entitled to nursing home care. Services must be provided on physician's orders as part of a written plan of care that is reviewed by a physician every 60 days. Home health services include part-time nursing care, home health aide care, and medical supplies and equipment. States have the option of providing physical therapy, occupational therapy, speech pathology, and audiology services.

A state has the option under Medicaid to offer personal care which provides assistance with activities of daily living such as dressing and bathing. Personal care services can also be covered under a home and community-based waiver, although most states have chosen to provide it as a separate optional service targeting it to persons who meet the states' functional impairment criteria. Services can be authorized by a physician as part of a plan of treatment or by a case manager as part of a service plan. Connecticut does not offer its frail elderly this option.

Medicaid waiver authority. In 1981, Section 2176 of the Omnibus Budget and Reconciliation Act allowed states to receive Medicaid waivers to provide home and community-based services to recipients who met the criteria for institutional long-term care services. The Section 2176 waiver, also known as a section 1915 (c) waiver of the Social Security Act, was designed to correct a bias toward institutional care in Medicaid services for the chronically ill by

allowing states to offer a broad range of home and community-based services to persons at risk of institutionalization. The rationale for these waivers was that individuals who would otherwise be institutionalized at the state's expense could be diverted from this costly option if services were available to support them in the home. Initial waivers are approved for a three-year period and renewable for five years. The Connecticut Home Care Program for Elders operates under this waiver.

Services covered. Under an approved waiver, states may cover a variety of nonmedical, social, and supportive services that are critical in allowing persons to remain in the community. In addition to home health services already covered by Medicaid (e.g. nursing, home health aide, physical therapy, speech therapy, occupational therapy, and medical transportation), additional "nonmedical" home care services were considered necessary to adequately support a frail elder in the community. These services included homemaker, home delivered meals, adult day care, chore help, non-medical transportation, companionship, emergency response systems, respite care, mental health counseling, and case management, as well as a variety of other services a state could request approval for in its waiver application.

Eligibility. The waiver allows states to limit its fiscal liability by specifying the number of slots that will be funded and target the waiver to serve specified numbers of frail elders, disabled adults and children, and other groups. Under the waiver, states may broaden eligibility requirements and provide waiver services to people who would not otherwise be eligible for Medicaid while living in the community by setting higher income eligibility levels. States may receive federal reimbursement for waiver and other Medicaid services to people with incomes up to 300 percent of the federal SSI payment standard, or $1,374 a month in 1995.

Cost neutrality. States however, were also required to demonstrate the cost-effectiveness of the waiver in order for a state to receive approval of its waiver application. The Health Care Financing Administration (HCFA) required that the average per capita expenditures under the waiver not exceed the average nursing home charges that would have been paid had the waiver not been granted.

Older Americans Act. The Older Americans Act (OAA) was enacted in 1965 to promote the well-being of older persons and help them remain independent in their communities. Under the act, federal funds are provided to assist in funding of elderly programs. The Older Americans Act requires states to partition themselves into planning and service areas (PSAs), based on the geographic distribution of the elderly population, concentrations of older persons in greatest economic and social need with special attention to the low income minority population, service availability, and concurrent political and administrative boundaries.

Area Agencies on Aging. Each PSA is served by one of the state's Area Agencies on Aging (AAA), which are private non-profit corporations. Their principal responsibility is to

develop a comprehensive and coordinated system of services designed to meet the needs of the older population within their PSA. This is primarily accomplished by funding a variety of local community providers who furnish services directly to needy elderly.

Funded services. A broad range of social services are funded. All persons age 60 and older are eligible to receive services, but states are required to target assistance to persons with the "greatest social or economic need." Table II-3 shows the specific services that must be provided to frail elderly under the act.

In federal fiscal year 94, funding nationally under the OAA was $1.3 billion. Since there are limited funds under the OAA, it is an inappropriate funding source for large statewide initiatives. In addition to home care, the OAA funds other types of long-term care including adult day care, respite for family caregivers, and care management. The most common services include health, transportation, housing assistance, community long-term care (meals, daycare, etc.), legal assistance, health promotion, and information and referrals.

Table II-3. Older Americans Act (OAA)

Title	*Designated Service*
Title III-B	Supportive Services
Title III-C1	Congregate Meals
Title III-C2	Home-Delivered Meals
Title III-D	Frail Elderly Services
Ombudsman Program	Elder Abuse

Source: LPR&IC.

The act also provides funding to states to maintain a long-term care ombudsman program. It is the role of the ombudsman to monitor the quality of care provided in nursing homes and to investigate and resolve complaints.

Connecticut received approximately $11 million in federal funds allocated under the Older Americans Act in federal FY 95. Approximately $6 million of this funding was earmarked by the act for elderly nutrition, through the provision of both congregate and home delivered meals. The

remainder was used by the area agencies to support services such as home care, transportation, outreach, and senior centers.[5]

Social Service Block Grant (Title XX). Title XX of the Social Security Act was enacted in 1974 by Congress authorizing an entitlement for states for social service funds with certain program goals and eligibility requirements. Block grants are provided to the states for a variety of home-based services for the elderly, as well as persons with disabilities and children. The five goals contained in Title XX are:

- achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;
- achieving or maintaining self-sufficiency, including reduction or prevention of dependency;
- preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating or reuniting families;
- preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; and
- securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions.

States are given wide discretion as to the services to be provided and eligibility for services. Types of services funded include: children and adult day care; employment; home and congregate meals; legal assistance; help with substance abuse; and home energy assistance. Connecticut used an estimated $2.3 million in SSBG funds for FY 96 to augment the state appropriation for the Connecticut Home Care Program.

Summary. Although many federal programs provide funding for elderly health and social services, only the Medicaid and the Medicaid waiver programs are designed to support the long-term care delivery system. In the next two chapters, the details of the Connecticut Home Care Program for Elders is presented. The program operates under a Medicaid waiver and represents the state's primary effort in providing home and community-based services to frail elderly.

[5]Department of Social Services, *State Plan on Aging*, October 1, 1995 to September 30, 1997.

KEY POINTS

CHAPTER THREE: CONNECTICUT HOME CARE PROGRAM - PROGRAM DESCRIPTION

- The CHCP began on July 1, 1992, and is housed in the Department of Social Services. The program is administered by five regional field offices and implemented by private care management organizations.

- The CHCP operates under a three-tiered structure that provides home and community-based services to recipients based on financial need and functional dependence. Two categories are primarily state-funded and the third is jointly funded by the state and federal government under a Medicaid waiver. Eligibility for services is based on income and assets, and on the extent of the client's impairment.

- Cost caps are imposed over each category and the cost of services cannot exceed the weighted average nursing facility cost, which as of January 1996, was $3,268.

- Twelve home and community-based services are offered in addition to home health services. The top three services include: homemaker, personal emergency response system, and meal service.

- The intake and monitoring process consists of five steps including: referral, initial screen by DSS field office, referral to an Access Agency for assessment, review of care plan by DSS, and continuing care management.

- The typical CHCP client is a white, female, between the ages of 80-84, and lives alone in elderly or other subsidized housing.

Chapter Three

CONNECTICUT HOME CARE PROGRAM - PROGRAM DESCRIPTION

The CHCP operates as an alternative for those at risk of nursing home placement. A wide array of services are available to assist in sustaining elders, who meet program requirements, in the community. Enrollment in the program is voluntary and is also dependent on the availability of funds. The total amount spent by the state on home care, under this program, is only 8 percent of the entire amount spent on long-term care. Further, a waiting list has been in effect intermittently for most of the life of the program. Still, the CHCP served a total of 8,569 clients in FY 95 and saved an estimated $20 million.[6]

History. The State of Connecticut has provided funding for nonmedical home care services for the state's frail elderly since the mid-1950s. This commitment to home care was made through the allocation of funds under the Department of Public Welfare for services like homemaking, chores, adult day care, home delivered meals, and companionship. By the late-1980s, the evolution of home care in Connecticut resulted in three separate programs operated by three different state departments.

The legislature adopted P.A. 90-182 and P.A. 92-16 which consolidated the three major home care programs: the Long Term Care Preadmission Screening and Community Based Services Program operated by the former Department of Income Maintenance; the Promotion of Independent Living program operated by the former Department on Aging; and the elder services portion of the Adult Services Program operated by the former Department of Human Resources. The new program, renamed the Connecticut Home Care Program for Elders, began on July 1, 1992, and is housed in the Department of Social Services' Alternate Care Unit. The unit oversees five regional field offices who are responsible for the day-to-day program operation. For a complete history of Connecticut's provision of home and community-based services see Appendix B.

Current Program Structure

The CHCP operates under a three-tiered structure that provides home

[6] DSS calculates this savings by adding the cost of program services and administrative costs to clients' Old Age Assistance payments and compares that total to what would have been spent if a client entered a nursing home. An allowance is made for delayed nursing home admissions and the fact that other Medicaid recipients may replace home care clients in the nursing home.

and community-based services to recipients based on financial eligibility and functional dependence. The first two categories are largely funded by state appropriations and include a small amount of funding from the federal Social Services Block Grant. The third category, referred to as the "waiver" category, is jointly funded by the state and federal government under a Medicaid waiver. Cost limits for each program category are established based on a weighted average nursing facility cost. The average monthly nursing facility cost, effective January 1, 1996, was $3,268. A description of each category is provided in Table III-1 below.

Table III-1. Eligibility Criteria for Connecticut Home Care Program for Elders: January 1996.

Category	*Description*	*Functional Need*	*Care Plan Limits*	*Funding Source*
Category 1	Limited home care for moderately frail elders	At risk of hospitalization or short term nursing home placement	<25% NH cost ($817/monthly)	State funded within available appropriation
Category 2	Intermediate home care for very frail elders with some assets above the Medicaid limits	In need of short or long term nursing home care	<50% NH cost ($1,634/monthly)	State funded within available appropriation
Category 3	Extensive home care for very frail elders who would otherwise be in a nursing home on Medicaid	In need of long term nursing home care	<100% NH cost ($3,268/monthly) Social Services cap = $2,305	Medicaid waiver with limits on # eligible and total dollars expended

Source: DSS: Connecticut Home Care Program For Elders Effective January 1, 1996.

Category one is targeted to individuals who are at risk of hospitalization or nursing facility placement if preventive home care services are not provided; since these are not individuals who would immediately need nursing home placement without the program, individual care plan limits are set at 25% of the average Medicaid cost in a nursing facility. As of June 30, 1996, there were 804 (13 percent) clients classified as category one.

Category two is intended for individuals who are frail enough to require nursing facility care but who are not actively considering it at the present time or who have resources that would prevent them from qualifying for Medicaid upon admission to a nursing facility. Care plan limits for these individuals cannot exceed 50 percent of the average Medicaid cost in a nursing facility. As of June 30, 1996, there were 1,389 (23 percent) clients classified as category two.

Category three is the Medicaid waiver category and is directed at individuals who would otherwise require long-term nursing home care funded by Medicaid. There are in effect two cost limits imposed on clients in this category. First, to assure cost effectiveness, total individual care plan costs cannot exceed 100 percent of the average Medicaid cost in a nursing facility. In addition, the cost of the community-based services alone cannot exceed 60 percent of the total care plan cost. As of June 30, 1996, there were 3,947 (64 percent) clients classified as category three.

Program administration. The state is divided into five regions and the department administers the program through contracts with local Access Agencies. The Access Agencies assist individuals in obtaining services by conducting assessments, developing plans of care, contracting with local providers and arranging for the delivery of services, and providing care management services to clients of CHCP.

Until the spring of 1996, Connecticut Community Care Incorporated (CCCI), the state's only licenced Coordination, Assessment, and Monitoring (CAM) agency, was the sole provider of care management services. However, Public Act 95-160 eliminated CAM licencing and required the department develop standards and solicit bids for a new type of health care provider called Access Agencies. As a result two Area Agencies on Aging (AAA), the Southwest AAA and South Central AAA , were awarded contracts to serve two of the five CHCP service regions. CCCI still serves the Eastern, North Central, and North West regions.

Waiting list. Due to funding limitations, a waiting list had been in effect since July 24, 1995, for the waiver portion of the CHCP and since October 10, 1995, for the state-funded portion of the program. Some of the people on the waiting list were eligible under the waiver but because that program closed admissions in July, they were able to receive services under the state-funded portion of the program. However, they are waiting for a waiver slot. As of June 30, 1996, 3,154 people were on the waiting list.

It is not known how many people would actually qualify for the program because a comprehensive assessment has not yet been completed. The program has recently opened the waiver part of the program on a limited basis. It is expected they will accept 298 clients per month from August through October and 212 clients per month for the remaining eight months. The state-funded portion remains closed.

Services and providers. The range of services offered by the CHCP includes both home health services and community-based services. In addition, Medicaid waiver clients are eligible for all medical services available under the regular Medicaid program. A description of the services provided under the CHCP is listed below in Table III-2.

Table III-2. Connecticut Home Care Program Covered Services

Service	*Description*
Adult Day Health Services	A community-based program designed to meet the needs of cognitively and physically impaired adults through a structured, comprehensive program that provides a variety of health, social, and related support services. There are two different models of adult day health services: the social model and the medical model.
Adult Family Living	The provision of continuous monitoring, supervision, and coordination of daily living activities and management of an individual's overall health and welfare on a 24-hour basis in the home of a non-related family, when necessary to prevent or dely institutionalization.
Care Management	Those activities that involve implementation, coordination, monitoring, and reassessment of a community-based plan of care.
Chore Services	The performance of heavy indoor or outdoor work or household tasks for individuals unable to do the tasks themselves. These services are necessary to maintain a healthy and safe environment for elders in their own home.
Companion Services	Home-based supervision and monitoring of activities that assist and/or instruct an individual in maintaining a safe environment, including the following activities: escorting individuals to medical or business appointments or recreational activities, supervising activities of daily living, reminding individuals to take self-administered medications, and reading to or for an individual.
Home Health Services	Home health services are defined in the same way and covered to the same extent as they are under the Medicaid program. They include: skilled nursing, home health aides, physical therapy, speech therapy, and occupational therapy.
Homemaker Services	General household management activities provided in the home on a part-time or intermittent basis to assist and/or instruct an individual in managing a household, including light housekeeping, laundry, meal planning and preparation, and limited money management.
Home Delivered Meals	The preparation and delivery of one or two meals a day for individuals who are unable to prepare or obtain nourishing meals on their own.
Laundry Services	Services designed to serve frail elders who have no other means of having laundry cleaned. This service is limited and does not include dry cleaning.
Mental Health Counseling	Professional counseling services provided to help individuals resolve or cope with individual, family, and/or environmentally related problems or conditions.
Respite Care Services	Short-term relief from the continuous care of an elderly person for the individual's family or other primary care giver(s). The primary purposes of respite care are to reduce stress on the care giver, to allow the care giver to meet other family needs, or fill in during a temporary absence of the primary care giver.
Personal Emergency Response System	An in-home, 24-hour electronic alarm system activated by a signal to a central switchboard, which enables a high-risk individual to obtain immediate help in case of a medical, physical, emotional, or environmental emergency.
Transportation	Services provided to assist individuals in accessing medical services, social services, community services, and appropriate social or recreational facilities.

Source: Connecticut Home Care Program, *Operations Manual*, May 31, 1996

Aside from care management, which nearly all clients require, the top three services used by CHCP clients in FY 95 were:

- Homemaker - served an average of 2,660 clients per month with an average monthly cost of $537 per client;
- Personal Emergency Response System - served an average of 1,685 clients per month at an average monthly cost of $57 per client; and
- Meal Service - served an average of 1,144 clients per month at an average monthly cost of $155 per client.

The Access Agencies, who provide care management services, are responsible for subcontracting with providers. The Access Agencies are not allowed to provide any direct services to the clients other than care management. All providers must have a written subcontract that conforms to standards established by DSS and must meet all the provisions of CHCP regulations before providing services. The agencies are expected to contract with all qualified providers of allowable services in order to assure that clients have a choice of providers.

Table III-3 shows the number of providers in each region by type of service. The table indicates the number of providers available in each region, not the number of different providers throughout the state. Due to data limitations, an unduplicated count of providers by service could not be ascertained.[7] However, an overall number of unduplicated providers was determined to be 389.

Connecticut Home Care Program for Elders Intake and Monitoring Process

The CHCP intake and monitoring process consists of five steps from initial referral to continuing care management as illustrated in Figure III-1. When funding is available and intake is open, an applicant may become a client within seven days. The application process is outlined in detail below.

Referral for services. There are three primary methods through which a person aged 65 and over may receive information about the Connecticut Home Care Program for Elders:

- Nursing home personnel are required to provide information about the program to anyone 65 and over seeking admission to the facility. Those elders, who are Medicaid recipients or applicants, are required to fill out a home care application and have a health screen performed to determine the feasibility of home care prior to admission to a nursing facility. Nursing home residents who wish to return to the community may apply for the program

[7] DSS maintains a database by region not by provider or by service.

Table III-3. CHCP Providers by Region, 1996.[1]						
	Eastern	*North Central*	*Northwest*	*South Central*	*Southwest*	*Other*[2]
Home Health Services						
Skilled Nursing	28	51	40	44	33	1
Home Health Aide	28	49	39	44	34	1
Physical Therapy	28	47	39	44	33	1
Speech Therapy	28	47	39	44	33	1
Occupational Therapy	27	47	39	44	33	0
Community Services						
Adult Day Care	9	31	20	29	36	0
Chore Service	12	21	13	14	17	0
Companion	20	36	25	27	29	2
Homemaker	27	55	46	43	43	2
Meal Service	5	17	5	8	4	0
Personal Emergency Response System	27	29	25	30	18	0
Mental Health Services	10	11	12	6	18	0
Elderly Foster Care	0	1	1	0	1	0
Social Transport	0	4	1	0	2	0

[1] Respite services are not included and are provided on a space available basis in nursing facilities

[2] Other category refers to providers who were not placed in a region in the DSS database

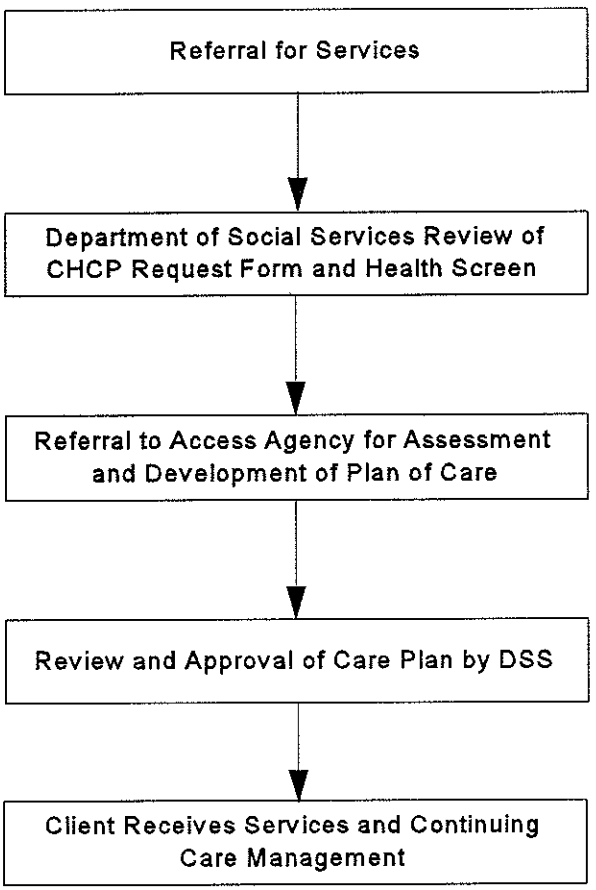
Source: LPR&IC analysis of DSS provider database

through the staff of the facility or by having a family member call the department to make a referral;

- Similarly, hospital discharge planners provide material about the CHCP to patients they expect to be placed in a nursing home. State regulations require that acute care hospitals distribute this information to the elder or their representative within three days of admission; and

- Finally, information may be obtained by contacting a field office directly or by calling the Alternate Care Unit's toll-free number.

Figure III-1. Connecticut Home Care Program Intake Process



Initial screen by DSS field office. The five Alternate Care Unit field offices are responsible for determining if the client is appropriate for the program, if the person is eligible for the program based on minimum requirements, or if the individual should be recommended for admission to a nursing facility. The key factors DSS clinical staff consider include: critical ADL/IADL needs; behavior problems and cognitive impairments; level of supervision required for applicant's behavior; informal support systems; and financial eligibility. In addition, clinical staff will make a preliminary judgement as to which category of service the client would qualify.

The DSS field offices conduct all initial eligibility screens for potential CHCP recipients in step two of the intake and monitoring process (Figure III-1). Applicants must complete two forms that are used by field office staff to determine whether the applicant should continue with the screening process. The Home Care Request Form asks the applicant for personal and financial information and is used to determine financial eligibility for the program. A field office employee can also take this information over the phone. Table III-4 provides the income and asset limits for the program as of January 1996.

Table III-4. CHCP Financial Eligibility, January 1996

	State-Funded	*Medicaid Waiver*
Income (monthly)	$1,410 or less	$1,410 or less
Assets[1]	Individual - $15,384 Couple Combined Assets - $23,022	Individual - $ 1,600 Couple (Both Receiving Services) - $ 3,200 Couple (One Receiving Services) - $16,948[2]

[1] Certain assets are not counted toward the limit such as the client's primary residence, furnishings, personal belongings, and motor vehicle.

[2] A higher amount may be allowed if a spousal assessment is completed which under federal and state law allows the nonparticipating spouse to protect additional assets.

Source of Data: Connecticut Home Care Program for Elders

The information for the Medicaid eligible recipients is verified by a DSS district office. However, for the state-funded program, the client only completes a self-declaration form. In addition, the department may request state-funded clients apply for Medicaid if it appears they

would be eligible for that program. If the client is noncompliant with this requirement, services are not rendered.

The second form reviewed by field office staff is the Uniform Health Screen. This may be completed by the applicant's physician, or a registered nurse or social worker in a nursing home or hospital. Clinical staff within the field office may also occasionally complete the screen for the applicant. The review of this screen by field office staff is to determine whether:

- the person should be admitted to a nursing facility without an assessment;
- the applicant needs a nursing facility level of care;
- the elder may be appropriately placed in the community without the creation of an unacceptable risk; and
- the applicant meets the functional level for admission to the program on a preliminary basis.

The field office staff usually make a determination within a 24-hour period. The decision made by field office staff, on whether to move to the next step, is valid for a maximum of 60 days. A review of initial determination information is required if there is a significant change in the applicant's condition.

Functional Status. Functional eligibility is based on how much assistance an elder needs in performing certain functions. As noted in Table I-1, Chapter One, two types of measures are used to evaluate a person's ability to function independently. They are activities of daily living (ADL) and instrumental activities of daily living (IADL). The field office staff review the Uniform Health Screen to determine if the applicant has limitations in one or more of the following: bathing, dressing, toileting, transferring, eating, meal preparation, and medication administration. The overall mental health and medical status, as well as availability of informal support (such as a family member), are also considered. The appropriate field office sends written confirmation to the applicant indicating the outcome of its review. If the applicant meets the necessary minimum requirements, he or she is referred to an Access Agency for an in-depth assessment.

Referral to Access Agency and assessment process. Up to this point, the CHCP has relied upon other health care professionals, the elder applicant, and/or the elder's representatives to provide information about the applicant. The CHCP staff use the information to make a preliminary determination about the applicant. The Access Agency's primary purposes, at this stage, are to confirm the extent of the functional limitations of the client and determine the individual's medical, psychosocial, and economic status by conducting a comprehensive assessment - the third step in the intake process (Figure III-1). If the applicant qualifies, the Access Agency will develop a care plan that addresses the client's needs.

The Access Agency must contact and set up an appointment with the applicant within one working day of receipt of a referral from a DSS field office. The Access Agency will administer a similar but more comprehensive evaluation of the applicant's ADLs, IADLs, mental and emotional status, and social support system. Clinical staff completes the assessment (a registered nurse or social worker) in a face-to-face interview with the applicant. The evaluator is not provided a copy of the initial screen to ensure an objective assessment. The Access Agency will also educate the applicant about the full range of services available, the rights and responsibilities of CHCP clients, and any fees that may be required toward the cost of care. The Access Agency has seven working days to complete the assessment and develop a plan of care.

Plan of care. If home care is considered appropriate, the Access Agency will involve the client and his/her family or representatives in developing a plan of care. The plan of care is a summary of all the services a client is receiving including the frequency and cost of those services. The Access Agency care manager will reiterate that the purpose of the home care program is to complement but not supplant existing help. All services, including family support and non-subsidized assistance, are incorporated in the plan. All financial resources must be exhausted, including Medicare and any third-party payers, before CHCP monies can be used to reimburse payment. Placement in one of the three program categories is dependent on an applicant's level of functional need and the development of a plan of care that is cost effective. (See Table III-1 for care plan limits.)

The applicant may not qualify for CHCP services if the person does not have the specific level of functional need, if the assessment is not completed, or if the plan of care is over the cost limits. The family of the applicant may choose, if able, to pay the difference when the plan of care exceeds the established cost limits. A sliding fee is also imposed on those clients who can afford to contribute to their plan of care.

Fees. Applicants who are offered services, may be required to contribute to the cost of those services depending on their monthly income. The department has established a sliding-fee scale based on federal poverty guidelines. A state-funded client is required to contribute if his/her income is equal to or greater than 150 percent of the federal poverty level. As of June 30, 1996, this equals $11,205 gross annual income. The sliding-fee scale is adjusted each year to reflect changes in the poverty level. Clients who qualify for the waiver are not required to contribute to their plan of care if their income is at or below 200 percent of the federal individual poverty level. The client's income is reviewed at the annual reassessment for any changes.

The Access Agencies are required to collect the client fees. The department reduces its reimbursement to the Access Agencies by the amount of the client fees. In the latest report, 310 clients had a fee due in the period and 23 clients were in arrears over 30 days owing a total of $6,867.

Review of care plan by the department. The Alternative Care Unit's field office authorizes services to be provided after a review of the plan of care to assure its adequacy and that it is within the category cost cap in step four of the intake and monitoring process. This usually involves a comparison of the initial screen with the subsequent assessment by the Access Agency and the plan of care to assure the elder's needs are addressed. If services cannot be provided or if it would be inappropriate for the elder to be cared for at home, nursing facility placement may be recommended.

The Access Agencies are able to modify the care plans with respect to the number and frequency of services offered without prior DSS approval as long as the cost limits are maintained. The only exceptions are some home health services and two community-based services (highly skilled chore services and any second installation of a personal emergency response system) that require prior authorization.

Administrative Exceptions. Occasionally, a client may require a care plan that exceeds the cost cap for the state-funded portion of the program. The care manager may request an administrative exception on behalf of the client which must be approved by the manager of the Alternate Care Unit. The reason for the request must be based on extreme hardship (e.g., the loss of a care giver) and if approval is granted it is time limited (no more than three months). Exceptions to the cap cannot exceed 100 percent of the average cost of a nursing facility. There were five exceptions granted in FY 95.

Continuing care management. Figure III-1 shows the final step of the intake and monitoring process. The Access Agency will implement the plan of care, subcontract with providers for the community services to be rendered, and arrange for actual delivery of services. Ongoing monitoring of the client can be conducted by either the Access Agency or the client may choose a self-directed care option.

For those clients receiving care management services from the Access Agency, the care manager has the ongoing responsibility for identifying changed circumstances that affect the client's eligibility or service needs, and changes in the availability of services. The care manager must contact the client or the client's family every month to check on the delivery of services. The care manager is also required to make home visits to the client as needed and at least every six months to determine the appropriateness of the care plan and to assess the condition of the client. Clients are evaluated for appropriateness of self-directed care at the time of their initial assessment, six months after the initial assessment, and annually thereafter.

Annual review. Annually, the care manager must also reassess the client's psychosocial, medical and economic status, degree of functional impairment, and related service needs. Through this reassessment, the care manager will also verify the individual can appropriately and cost-effectively continue to be served in the community. In cases where a CHCP client is

hospitalized or placed in a long term care facility for short-term rehabilitation, the care manager may conduct a status review to determine the appropriateness of the client's return to the program and the need for care management services.

Self-directed care. For those clients wishing to be in charge of their own care management, they may choose, with the approval of DSS field office staff, the self-directed care option. Self-directed care assumes that the client and/or family, under certain circumstances, can work directly with provider agencies to effectively coordinate and monitor the client's care without the assistance of an independent care manager. The department began self-directed care in 1993 and reevaluated all of its clients to determine their eligibility for this option. Clients who are approved for self-directed care must have their plans of care reviewed and reauthorized by the Alternate Care Unit every six months and have a reassessment conducted annually. By June 30, 1996, there were 428 clients who were self-directed. This represents 7 percent of the total caseload. The department has established a goal of increasing the total number of self-directed clients to 10 percent of the total caseload for 1996.

Screening statistics. In fiscal year 1995, the Alternate Care Unit screened 13,044 applicants. Approximately 5,000 (38 percent) of those applicants were referred for assessment. The program ultimately accepted 3,272 people as new clients. This represents 25 percent of the original number screened.[8]

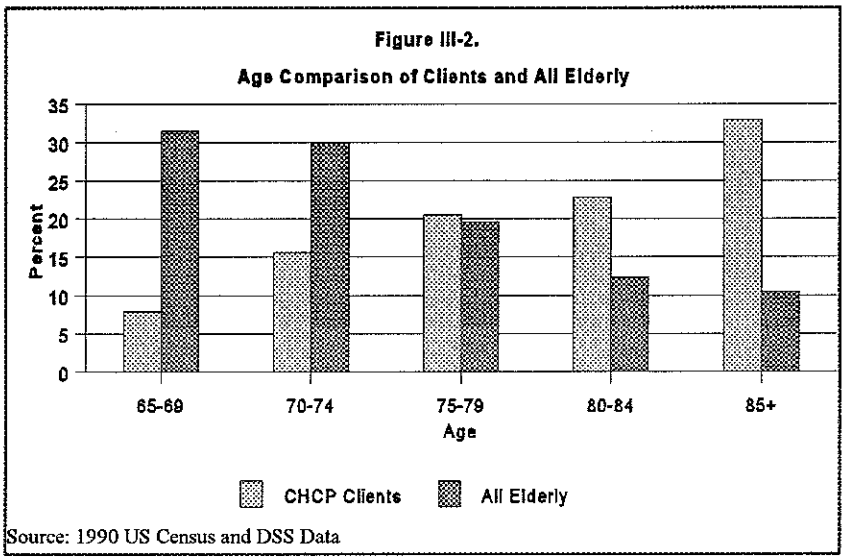
Client Population

Demographics. The assessment instrument administered by the Access Agencies collects not only clinical information about CHCP clients but also demographic and social information. Based upon this source, a profile of the typical CHCP client emerges as a white, female who is between the ages of 80-84. She lives alone in elderly or other subsidized housing and receives her primary support from her child or other relative. The analysis below is based on demographic data provided by CCCI for elders enrolled in the program. Where appropriate, these data are compared with census statistics on the entire elderly population (65 and over) in Connecticut found in Chapter Six.

- *Age.* As Figure III-2 demonstrates, the elders in the CHCP are older than Connecticut's elderly population as a whole. Seventy-six percent of program clients are over the age of 75, but only 43 percent of all elderly fall into that category. Similarly, CHCP clients comprise a larger proportion of individuals

[8] Department of Social Services, *Annual Report on CHCPE, July 1,1994 through June 30, 1995*, p. 24.

over 85 compared with the entire elderly population (33 percent versus 11 percent).

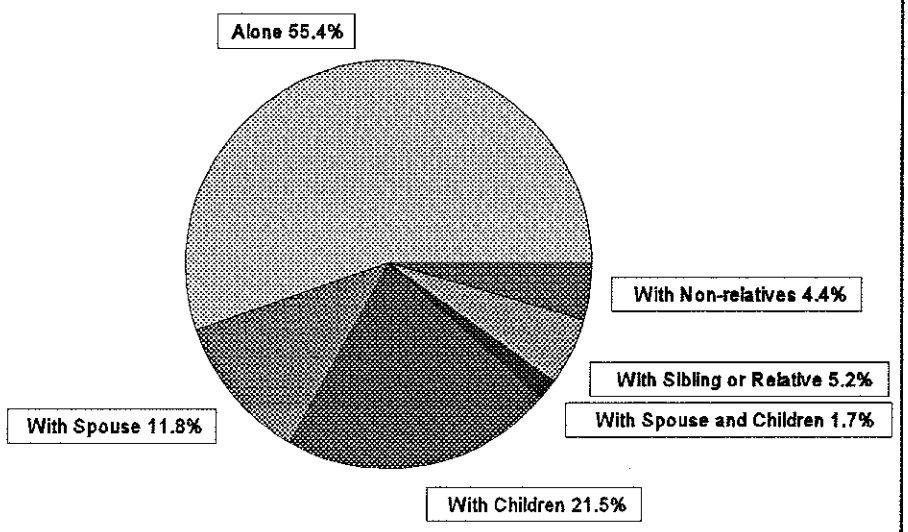


- *Gender.* The state's elderly as a whole and those in the CHCP are predominantly female. However, the program tends to have more female members than the entire population (80 percent in the program versus 60 percent in the general population).

- *Race.* While Caucasians make up the largest group in the CHCP and the elderly population as a whole, the CHCP is more ethnically diverse. Minority populations comprise 21.1 percent of the CHCP, but only 6.2 percent of the entire elderly population. The largest minority group in the program is Blacks (14.8 percent), followed by Hispanics (5.6 percent), Asians or Pacific Islanders (.4 percent), and American Indians and Others (.3 percent).

- *Living arrangement.* Figure III-3 shows the living arrangements of the clients in CHCP. The majority of clients (55 percent) live alone. This contrasts with the larger elderly population where only 27 percent live alone.

Figure III-3. CHCP Client Living Arrangements



Source: DSS Data

- *Housing.* Thirty-one percent of CHCP clients either own their own home or live in a home owned by a relative. The remaining 69 percent of CHCP clients live in housing designated as either elderly or other subsidized housing (42.2 percent), low income (5.2 percent), or a boarding home (2.8 percent). Approximately 19 percent live in apartments, trailers or other housing.

- *Income.* Because of eligibility guidelines based on income, the CHCP clients are much poorer compared to Connecticut's entire elderly population. Six percent of CHCP clients have an income of less than $5,000. Most CHCP clients (75 percent) have an income between $5,000 and $9,999, while 17 percent earn between $10,000 and $14,999. Approximately 2 percent earn more than $15,000. This is in contrast to the larger elderly population where 64.4 percent earn over $15,000.

- *ADL and IADL dependencies.* The top three ADL dependencies exhibited by CHCP clients are: bathing (90 percent), stair climbing (80 percent), and dressing (74 percent). The top three IADL dependencies are: housekeeping (99 percent), shopping (95 percent), and laundry (97 percent). As one would expect, the elderly population in Connecticut is less dependent than the average CHCP client. While close to 80 percent of all elderly report some form of chronic ailment, only 16 percent say it prevents them from performing some essential activity.

- *Cognitive impairments.* When screening for cognitive impairments, the clients are asked 10 questions from a Mental Status Questionnaire (MSQ). The responses are tabulated into an MSQ score. Sixty-two percent of CHCP clients were found to have no or minimal cognitive impairments. Thirty-one percent were found to have moderate impairment, and 7 percent had severe impairment.

KEY POINTS

CHAPTER FOUR: CHCP EXPENDITURES AND COST-EFFECTIVENESS

- Given the current level of client data, the program review committee found it difficult to quantify the impact of CHCP on nursing bed utilization.

- Fully 26 percent of CHCP clients need help with three critical functions and 47 percent have four or more critical needs.

- Many CHCP clients receive multiple health and social service supports. Of 6,246 CHCP clients, 1,868 receive support from two other publicly-funded programs and 61 percent received assistance from three or more other programs.

- To demonstrate cost-effectiveness under the federal standards for Medicaid waivers the federal government requires the department show the per capita cost for program participants is less than institutional care. Using these standards, the average cost-per-client for CHCP is lower than the per capita cost of nursing care and therefore the program is cost-effective.

- The average monthly cost provided to clients under the CHCP was $516 for state-funded clients and $1,333 for waiver clients. The overall average client cost was $948, significantly below the average monthly Medicaid nursing home rate of $3,268.

- Overall program expenditures increased 60 percent from $52.7 million in FY 93 to $84.3 million FY 96. While the state-funded portion of the program decreased by 17 percent over that period, the waiver portion has more than doubled.

- The department determined the program served a total of 8,569 clients in FY 95 and estimates the waiver portion saved the state $20 million by diverting clients from nursing facilities.

- The top four services in client utilization were case management, homemaker, personal emergency response system, and meals. Two of the most highly used services -- meals and personal emergency response system -- are also among the least expensive to provide on a per client basis.

Chapter Four

CHCP EXPENDITURES AND COST-EFFECTIVENESS

A primary concern of committee members was whether the provision of home and community-based care diverts individuals from entering a nursing home and therefore reduces institutional costs. Comparisons between services provided by CHCP and nursing facilities are somewhat misleading. First, it is difficult to measure whether the two populations are equal in terms of severity of illness or level of care needed. Also, nursing home residents may receive the majority of services provided in a nursing home while home care clients receive a limited number of services. In addition, room and board is a major component of nursing home care, as well as 24-hour nursing care, services that are not provided under CHCP. In this chapter the issues surrounding the calculation of cost-effectiveness for the CHCP are examined. In addition, program expenditures as well as direct and administrative costs are analyzed.

Cost-Effectiveness of CHCP

Several studies completed in the late 1980s examined other states' home and community-based programs. These studies found, in general, home and community-based programs provide a transition for elders who do not need the intensive level of care provided in nursing homes. The studies also suggested home and community-based programs do not significantly reduce nursing home utilization, but do greatly impact the quality of an elders life, and have a positive effect on families caring for a frail elderly relative. However, none of these studies specifically examined Connecticut's home and community-based program where differences in the program design, and the cost and level of services provided in nursing homes could impact the research outcomes.

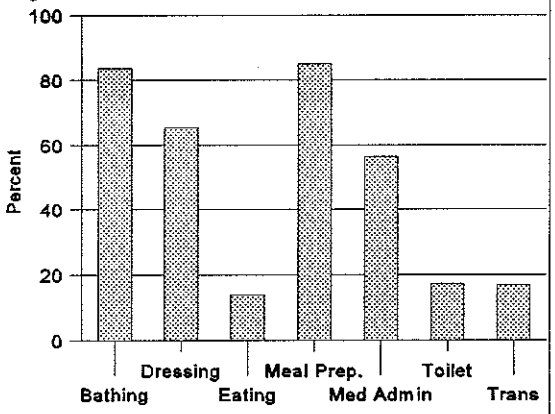
Given the current level of client data, the program review committee found it difficult to quantify the impact of CHCP on nursing bed utilization. In addition to data limitations that prevented comparisons between the two populations, two other factors affected the ability of the committee to evaluate the number of elders diverted from institutional care. Each of these is discussed below.

Cost avoidance. One factor that makes it difficult to determine the cost-effectiveness of CHCP is whether in practice the program actually functions as a substitute for nursing home care. Although almost all elderly served by CHCP (with the exception of those in the Category One state-funded program), are eligible for nursing home admission (using the screening

criteria for elders eligible for Medicaid as outlined in Chapter Five), it is doubtful that all clients would actually seek nursing home placement in the absence of CHCP services. Thus, CHCP services may not always be used by individuals who have been diverted from nursing homes, but also may be used by individuals who would never enter a nursing home. In fact, some elders would struggle alone in order to remain in their own home, others rely more heavily on family support, and many would use a patchwork of programs available to them in their communities.

Although many elders may not seek nursing home placement even though they are eligible, they may actually need some level of services to maintain their health and safety, and improve their quality of life in the community. The committee examined the functional status of CHCP clients active on December 31, 1995, to determine the level of frailty among program recipients. Figure IV-1 shows the percent of clients with dependence in performing seven critical daily functions. In addition, Table IV-1 shows that most clients have multiple limitations -- fully 26 percent of CHCP clients need help with three critical functions and 47 percent have four or more critical needs. These clients are not in nursing homes but certainly benefit from services provided through CHCP to assist them in the tasks of everyday living.

Figure IV-1. Deficiencies in Seven Critical Needs



Source: LPR&IC analysis of December 31, 1995, CCCI data of CHCP clients obtained from DSS, 1996. N=6,246

Table IV-1. Total Number of Critical Needs

Number of Critical Needs	*Number of Clients*	*Percent*
1	637	10%
2	862	14%
3	1,593	26%
4	1,528	25%
5	569	9%
6	414	7%
7	364	6%

Note: 279 clients were missing critical need information. N = 6,246
Source: LPR&IC analysis of December 31, 1995, CCCI data of CHCP clients obtained from DSS, 1996.

Service use. Cost-effectiveness is also difficult to determine because persons who are served at home or in community-based setting may receive other forms of government support that persons in nursing facilities do not receive. Thus, the cost-effectiveness of home care compared to nursing home care depends on what is included in the calculation of services provided to the client. For example, some clients on CHCP receive other publicly funded programs such as food stamps, fuel assistance, or rental subsidies. Table IV-2 shows the number of clients and the type of other public support received by CHCP clients. The table does not include individuals receiving payments from Social Security.

Table IV-2. Other Public Supports

Type	*Number Receiving*	*Percent Receiving*
Medicare	5,944	95%
Medicaid	5,078	81%
Rental Assistance	1,929	31%
Food Stamps	1,881	30%
Fuel Assistance	1,809	29%
SSI	1,113	18%
State Supplement	908	15%
Veterans Medical	264	4%
Other	76	1%

Source: LPR&IC Analysis of December 31, 1995, CCCI data of CHCP active clients obtained from DSS.

In addition, many frail elderly may receive multiple health and social service supports. The total number of other public supports received by CHCP clients is shown in Table IV-3. The table shows 30 percent of CHCP elders also receive support from two other publicly-funded programs. Many CHCP clients (61 percent) received assistance from three or more other programs.

Table IV-3. Number of Other Public Supports.		
Number of Other Programs	*Number of Clients*	*Percent*
0	9	0.1%
1	597	9.6%
2	1,868	29.9%
3	1,636	26.2%
4	1,219	19.5%
5	654	10.5%
6	230	3.7%
7	29	0.5%
8	4	0.1%

Source: LPR&IC Analysis of December 31, 1995, CCCI data of CHCP active clients obtained from DSS.

The average monthly nursing facility cost, effective January 1, 1996, was $3,268. If a client's total package of public benefits were calculated, including services provided under the CHCP, some clients may equal or even exceed the costs of providing care in a nursing home. However, under the cost-effectiveness provisions of the federal Medicaid waiver program, costs associated with the provision of other public programs are not required to be added to the cost of providing CHCP services.

Estimate of cost-effectiveness. The department considers the Medicaid waiver and the state-funded program separately when examining cost-effectiveness of providing services. In order to demonstrate cost-effectiveness under the federal standards for Medicaid waivers, the federal government requires the department show the per-capita cost for program participants is less than institutional care. As long as the cost of home and community-based services for each individual is less than the Medicaid cost of care in a nursing facility, the waiver program is considered cost-effective.

In addition to the federal regulations, the CHCP is required, by statute, to be cost-neutral overall. Specifically, section 17b-342 (a) of the Connecticut General Statutes states that, "[t]he program shall be structured so that the net cost to the state for long-term facility care in

combination with the community-based services under the program shall not exceed the net cost the state would have incurred without the program."

DSS cost saving estimates. The Department of Social Services calculates the cost-effectiveness of the waiver program in aggregate and uses a more conservative methodology than required by federal regulation to satisfy both federal and state requirements. DSS determines the program savings under the waiver by adding the cost of program services and administrative costs to clients' Old Age Assistance payments and compares that total to what would have been spent if a client entered a nursing home. An allowance is made for delayed nursing home admissions and the fact that other Medicaid recipients may replace home care clients in the nursing home. Using this methodology, the department reported an annual savings of $20,185,048 for FY 95 in the waiver program. However, cost-effectiveness measure is not done on an individual basis for waiver clients.

A similar calculation is not done for state-funded clients since they are not Medicaid eligible and would have to spend down their income and assets if they entered a nursing home. The state-funded portion of the program is limited by appropriation. The department reasons that since it does not spend in excess of the appropriation, it meets the statutory requirement for the state-funded clients.

Program Resource and Expenditures

Given the caveats outlined, the committee examined the costs of providing CHCP services using the federal standard for approval of the Medicaid waiver -- the average monthly cost per client for CHCP services was compared to the average monthly per capita Medicaid nursing home rate. In addition, the program review committee examined overall program expenditures and determined administrative and direct service costs for the program. Direct service costs were further broken down to obtain information on average cost per client.

Program expenditures. As noted earlier, the CHCP has two components; one that is primarily state funded and another that is jointly funded by the state and the federal government under a Medicaid federal waiver. Table IV-4 shows overall program expenditures increased 60 percent from $52.7 million in FY 93 to $84.2 million in FY 96. Although the state-funded portion of the program decreased by 16 percent over the four-year period, the waiver portion has doubled. One reason for this is shifting expenditures from state-funded clients to waiver clients, allows the state to capture more Medicaid dollars. In addition, clients served under the waiver have higher cost limits and therefore, may receive more services.

Table IV-4. Connecticut Home Care Program Expenditures, FY 1993 - 1996.								
Program	*FY 93*	*FY 94*	*Percent Change*	*FY 95*	*Percent Change*	*FY 96*	*Percent Change*	*Percent Change 93-96*
State-Funded	$19,447,641	$11,300,114	-42%	$10,953,360	-3%	$16,276,981	49%	-16%
Waiver	33,326,314	40,421,482	21%	56,407,088	40%	68,012,637	21%	104%
Total	$52,773,955	$51,721,596	-2%	$67,360,448	30%	$84,289,618	25%	60%

Source: CHCP, Annual Reports FY 1993-1995; Letter to the program review committee's staff from Michael Starkowski, Deputy Commissioner, DSS, October 22, 1996

State-funded category expenditures. Expenditures for the state-funded portion of the program decreased 42 percent in FY 94, but grew 49 percent from FY 95 to FY 96. Still, as a proportion of total program expenses, the state-funded categories have decreased from 37 percent of total expenditures in FY 93 to only 19 percent in FY 96.

Waiver-category expenditures. The waiver portion of the program experienced an increase in expenditures each year from FY 93 to FY 96 (Table IV-4). As a proportion of total program expenses, the waiver category increased from 63 percent of total expenditures in FY 93 to 81 percent in FY 96. Paralleling trends in the state-funded category, expenditures in the waiver category increased in the last fiscal year even though intake had been closed from July 24, 1995 through August 1996.

Net state expenditures. The Medicaid waiver portion of the program receives a 50 percent match from the federal government for all expenditures. The state also applies federal funds from the Social Services Block Grant to the state-funded portion of the program. In Table IV-5, federal contributions have been subtracted from the total expenditures for the program to derive the net state expenditures. The table indicates the effect of increasing the number individuals under the waiver, as discussed earlier, on the state's share of overall program expenditures. In FY 93, the state shouldered 65 percent of total program costs. By FY 96, this proportion dropped to 57 percent.

Administrative and Direct Service Costs

Administrative and direct service costs are depicted in Table IV-6 for FY 93 through FY 95. Care management and assessment/status reviews, largely provided by the Access Agencies, are considered separately because these services share traits of both the administrative and direct service categories. Administration costs represent the expenses of DSS for the management of the program while direct services are furnished by a network of providers. The administrative costs incurred by the Access Agencies for care management are not shown in this table.

Table IV-5. CHCP Net State Expenditures, FY 1993 - 1996.

	FY 93	*FY 94*	*Percent Change*	*FY 95*	*Percent Change*	*FY 96*	*Percent Change*
Total Expenditure	$52,773,955	$51,721,596	-2%	$67,360,448	30%	$84,289,618	25%
Less Medicaid	(16,663,157)	(20,210,741)		(28,203,544)		(34,006,318)	
Less SSBG*	(1,940,273)	(3,032,373)		(1,140,543)		(2,300,000)	
Total Net State Expenditure	$34,170,525	$28,478,482	-17%	$38,016,361	33%	$47,983,300	26%
Percent State Funding of Total	65%	55%	-15%	56%	2%	57%	2%

* Social Services Block Grant

Source: CHCP, Annual Reports FY 1993-1995; Letter to the program review committee's staff from Michael Starkowski, Deputy Commissioner, DSS, October 22, 1996

Table IV-6. Administrative and Direct Service Costs FY 93-FY 95

	FY 93	*%*	*FY 94*	*%*	*FY 95*	*%*
DSS Administration	$856,651	1.6	$947,696	1.8	$1,243,749	1.8
Assessment/ Status Reviews (Access Agencies)	633,993	1.2	664,633	1.3	1,510,234	2.2
Care Management (Access Agencies)	8,292,271	15.7	7,762,467	15.0	9,732,115	14.4
Direct Services	42,991,040	81.5	42,346,800	81.9	54,874,350	81.5
Total	$2,773,955	100.0	$51,721,596	100.0	$ 67,360,448	100.0

Note: Percentages may not add to 100 due to rounding
Source: CHCP Annual Reports FY 1993 - FY 1995

As shown in the table, all costs have remained in roughly the same proportion throughout the first three years of the program. Direct services have remained the largest expenditure category at 81.5 percent in FY 93 and FY 95. As a share of total costs, care management declined from 15.7 percent to 14.4 percent, while assessment/status review increased from 1.2 percent to 2.2 percent.

Comparison of state-funded costs and clients. Table IV-7 shows the average monthly clients and the average monthly cost-per-case for state-funded clients for FY 93 through FY 95 for direct services. The number of average monthly clients decreased 56 percent in FY 94 because intake for new clients into the state-funded categories was closed for the first two years (FY 93 and FY 94). In addition, the average monthly cost per case increased 29 percent in FY 94 indicating that more services were being provided to fewer clients.

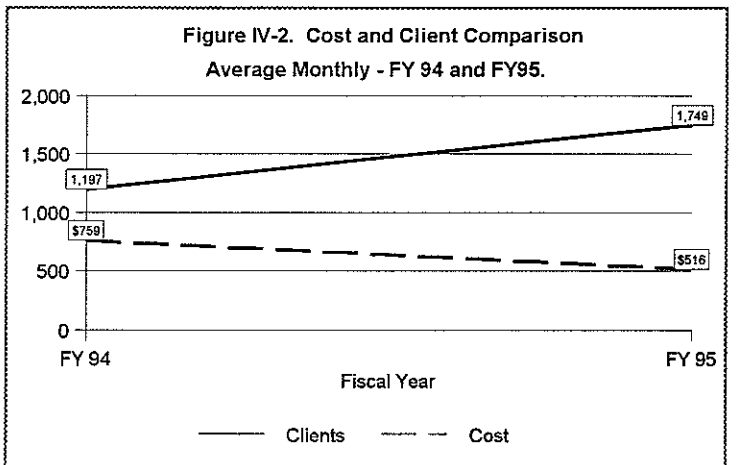
Table IV-7. Average Monthly Clients and Cost per Case for State-Funded Category, FY 1993-1995.[1]

	FY 93	*FY 94*	*Percent Change*	*FY 95*	*Percent Change*
Clients	2,697	1,197	-56%	1,749	46%
Cost	$589	$759	29%	$516	-32%

[1] Average monthly cost is calculated by dividing the average monthly expenditures by average monthly participating clients. Average monthly cost does not include the cost of screening services or administrative expenses.

Source: CHCP Annual Reports FY93 -FY95

In FY 95, the opposite trend occurred -- the number of average monthly clients increased 46 percent and the average cost per client decreased 32 percent, as shown in Figure IV-2. The data suggest more clients were being serviced at lower costs. The legislature appropriated $15.7 million for the state-funded program in FY 95 so intake could be opened and more clients served. However, the department only expended $10.9 million. This resulted



Source: LPR&IC Analysis.

in the department underspending their FY 95 appropriation and having to institute waiting lists in FY 96 so as not to overspend their FY 96 appropriation.

Average monthly cost per client for FY 95. Table IV-8 shows average monthly cost of home and community-based services provided to clients under the CHCP was $516 for state funded clients and $1,133 for waiver clients. Thus, the overall average client cost was $948, significantly below the average monthly Medicaid nursing home rate of $3,268.

Table IV-8. Average Monthly Cost: FY95*

	Average Monthly Clients	*Average Monthly Cost*
State-Funded	1,749	$516
Waiver	4,085	$1,133
Total Average Cost	5,831	$948

*Note: Assessment/status review costs and DSS administrative expenses are not included in average monthly cost.
Source: CHCP Annual reports.

Cost per client by service. Table IV-9 shows the annual expenditures for home and community-based services for both the state-funded and waiver parts of the program for FY 95. It is important to note that the department is unable to calculate the actual cost of home health expenditures and therefore, the table does not provide the expenditures by type of home health service provided. The department can only estimate the cost of home health expenditures due to deficiencies in its data systems. Total expenditures for community-based services were $39,421,891 and for home health care were $26,906,130. The top four services, in terms of community-based expenditures in FY 95 were homemaker, case management, adult day health, and companion services. The table also shows the average monthly cost per client for community-based services was $563 and $385 was estimated for home health services.

The mix of community-based services change when top services are considered in terms of average monthly client utilization. Case management with an average monthly cost of $159 was received by nearly all clients. The next three top services, for average monthly clients were homemaker, personal emergency response system, and meals. Two of the most highly utilized services - meals and personal emergency response system - are also among the least expensive to provide on a per client basis.

Table IV-9. Annual Expenditures for Community and Home Health Services: FY 95.

Type of Service	*Total FY 95 Expenditure*	*Average Monthly Clients in FY 95*	*Average Monthly Cost[1] per Average Monthly Client*
Adult Day Health	$5,840,971	639	$762
Case Management	9,732,115	5,108	$159
Chore	451,481	224	$168
Companion	2,623,102	394	$555
Elderly Foster Care	8,724	1	$727
Homemaker	17,175,984	2,666	$537
Meals	2,134,180	1,144	$155
Mental Health Couns.	236,791	125	$158
Non-Medical Transportation	6,701	6	$93
Personal Emergency Response	1,162,153	1,685	$57
Respite	49,689	9	$460
Total Community-based Services	$39,421,891	5,831	$563
Total Home Health Services[2]	$26,906,130	5,831	$385
Total	$66,328,021	5,831	$948

[1]Average Monthly Cost=annual expenditures/12 months/average monthly clients.
[2] Expenditures for home health services are based on estimates. Services include skilled nursing, home health aide, and physical, occupational, or speech therapy.
Source: CHCP FY 95 Annual Report.

There are 17 home and community-based services that may be provided by the CHCP program. The committee examined the number of CHCP services utilized by clients who had active plans of care as of December 31, 1995. Table IV-10 shows the majority of clients (68 percent) receive three or less CHCP services. The intensity and frequency of the services provided were not analyzed the committee. However, although the plan of care can change often, it would appear from the data CHCP clients rely on a few core services to assist them in the community.

Table IV-10. Number of CHCP Services Utilized.		
Number of Services	*Number of Clients*	*Cumulative Percent*
1	1,035	16.6%
2	1,505	40.7%
3	1,693	67.8%
4	1,197	86.9%
5	625	96.9%
6	166	99.6%
7	24	100%
8	1	100%

Source: LPR&IC analysis of CCCI data obtained from DSS on active clients for December 31, 1995.

Benefits of home and community based care. Given the data limitations and the assumptions that would need to be made, it is extremely difficult to calculate the impact of CHCP on utilization of nursing home beds. However, if the standards used by the federal government for approval of the waiver are applied, the average cost-per-client for CHCP is lower than the per capita cost of nursing care and therefore the program is cost-effective. In addition, there are several benefits in providing CHCP services that are not part of the cost calculation and should be considered when funding decisions are made. Most frail elders prefer to remain in their homes and communities. The CHCP provides assistance for those frail elders who live in the community and most importantly, has a positive impact on their quality of life. In addition, the program can provide relief for informal caregivers helping to care for a frail elder.

Informal caregivers play an important role in helping frail elders remain in the community and in delaying or preventing nursing home placement. Informal caregivers can be spouses, children, other relatives, friends, or neighbors. CCCI collects information on the assistance provided by informal caregivers and applies a financial model that provides a cost estimate of how much informal services is being provided. CCCI reviewed care plans of 5,467 clients from December, 1995 and determined that informal caregivers are providing approximately $5,432,121 per month ($65 million annually) of services to CHCP clients. The most frequently provided

informal service is financial management, followed by household management, supervision, shopping, personal care, and safety checks.

Government needs to decide how much care outside of nursing homes society is willing to pay for, who should receive it, and how a more efficient long-term care system can be designed.[9] Demand for program services as evidenced by the existing waiting list is high and indicates unmet need exists among frail elders. Results from the survey described in Chapter Seven of this report indicate that a continuum of long-term care service options needs to be more fully developed. In addition according to those surveyed, if CHCP services were available, it would prevent nursing home care in some instances. Finally, families may provide support for longer periods of time to a frail relative if there is other assistance available to relieve them of the stress involved in caring for a frail elder.

[9] Kemper, Applebaum, and Harrigan. *Community Care Demonstrations: What Have We Learned.* Health Care Financing Review, Summer 1987, volume 8, number 4.

KEY POINTS

CHAPTER FIVE: OTHER DELIVERY SYSTEMS: SUPPORTIVE HOUSING ARRANGEMENTS AND NURSING FACILITIES

- Supportive housing arrangements serve people who need assistance with long-term care but do not need intensive nursing services.

- Supportive housing models include congregate housing, continuing care retirement facilities, managed residential communities, and residential care homes.

- Government subsidies are provided for the development and operation of congregate housing. Public funding for the other types of housing arrangements is extremely limited or nonexistent.

- Two screens are performed by DSS on individuals aged 65 or older seeking admission to a nursing home. The first screen identifies individuals who may be exhibiting signs of mental illness or mental retardation, and the second screen determines the need for nursing home care and the feasibility of providing home care for Medicaid eligible individuals.

- As of September 30, 1994, Connecticut had 356 nursing facilities with 32,173 licenced beds.

- Nursing facilities provide housing, meals, medical , and nursing care, as well as assistance with personal hygiene and social activities supervised by professionals on a 24-hour basis.

- In FY 96, the estimated per diem Medicaid reimbursement rate was $109.38 or $39,924 annually. The Medicaid nursing home population was estimated at 21,100 for FY96, a growth rate of 5,154 in eight years.

- Based on data for September 30, 1994, the majority of nursing home residents are: admitted from a hospital, at least 75 years old, and white. The average length of stay in a nursing home is 2.6 years, and the source of payment, on September 30, 1994, for 66 percent of residents was Medicaid.

Chapter Five

OTHER LONG-TERM CARE DELIVERY SYSTEMS: SUPPORTIVE HOUSING ARRANGEMENTS AND NURSING FACILITIES

The other two components of the long-term care system are supportive housing arrangements and nursing facilities. Some elders enter a nursing home because they do not have the type of housing that meets their needs nor are their families able to provide them with the appropriate level of care. Others, require nursing home care because of a major illness, substantial needs based on ADL status, or cognitive disabilities that require intensive nursing supervision. Nursing home care may also be needed when an individual lacks the financial resources to pay for either home delivered services or supportive housing since there are limited public funds that support these options.

Supportive Housing Arrangements

Supportive housing arrangements serve people who need assistance with long-term care, but do not need intensive nursing services. The availability of supportive housing options for senior citizens is an integral part of a comprehensive long-term care system. However, most states have tended to develop long-term care policies and fund long-term care services without connecting them to elderly housing programs. With the increasing costs associated with nursing home care over the last several years, more attention has focused on establishing a long-term care model that emphasizes supportive housing arrangements. If supportive housing were available and affordable, many people who could not live independently would still be able to avoid entering a nursing home.

Funding. The state provides funding for the development of elderly housing and for congregate units. Government support for the development of other types of supportive housing, or ongoing rental assistance is extremely limited or nonexistent.

Need. There are approximately 6,800 elderly housing units within the state but supportive services are not required to be provided. (Although some are beginning to offer some supportive services and employ resident service coordinators.) In addition, there are 817 congregate housing units within 21 developments that provide limited long-term care services to the elderly. These resources, though, have proven inadequate as over 11,000 individuals are waiting for acceptance into elderly, moderate income, and

congregate housing units. This need, in combination with the growing elder population, demonstrates the demand for additional housing options. Table V-1 describes the major supportive elderly housing arrangements and inventories the number of developments and beds/units available.

A number of different supportive housing models are currently in use to serve people who need assistance with long-term care. These include residential care homes, managed residential facilities, continuing care retirement facilities, and congregate housing. While there is variability between individual facilities, a brief description of the services available within each type of housing is shown in Table V-2.

Congregate housing. Generally this type of housing refers to residential buildings with separate apartments, shared dining facilities, a community area, and kitchen facilities. A staff person is on duty 24 hours a day, all units contain an emergency call system, and a least one main meal per day is served to residents. Congregate housing is promoted by the state through grants and/or loans to eligible developers for the construction of congregate housing for frail elderly. An operating subsidy is also available to offset the expense of congregate services provided to lower-income residents. Eligible residents must be at least 62 years old, frail, and meet statewide maximum income guidelines. The rent is fixed, and eligible residents pay the fixed fee regardless of income.

Continuing care retirement facilities. These facilities provide shelter and various medical services or other health related benefits for a person's lifetime. A residence purchase is usually required at about $100,000 to $300,000. An additional monthly fee may also be assessed. Continuing care facilities are registered with the state and are required to disclose various financial and operational information. There also are minimum statutory requirements governing contractual relationship between facilities and clients. There are no government subsidies provided for these facilities.

Managed residential communities. Assisted living has emerged as a model to link supportive housing for the frail elderly with the long-term care system. Without a single universal definition available, states have used a variety of approaches to implement this model. Generally, public regulation has focused on : the physical setting; the scope of services provided; and the residents to be served. Three service delivery models have evolved:

- ***Institutional Model*** - States regulate and license multiple occupancy rooms, shared bathrooms. This setting does not serve people who qualify for nursing home placement or provide skilled services;

Table V-1. Descriptions of Elderly Housing Options and Housing Inventory

Type	*Description*	*Number of Developments*	*Number of Beds/Unit*	*Average Number of Residents*	*Licensed by the State*	*Average Cost per Month*
Congregate Housing	Residential environment consisting of independent living assisted by congregate meals, housekeeping and personal services, for persons 62 years or older, who have temporary or periodic difficulties with one or more essential activities of daily living	22	860	39	Yes	$721
Continuing Care Retirement Facilities	Facilities governed by a continuing care-contract which require a provider to furnish shelter and medical or nursing services or other health-related benefits for the life of a person or for a period more than one year, and which requires a transfer of assets or an entrance fee in addition to or instead of periodic charges	14	2,556	200+	No[1]	$1,200 to $1,400 plus unit purchase
Managed Residential Communities	A facility consisting of private residential units that provide a managed group living environment, including houses and services primarily for persons age 55 or older	10	n/a	50-200	No[2]	$1,600+
Nursing Homes	A facility that in addition to furnishing food and shelter provides personal care with nursing supervision under a medical director 24 hours per day and may carry out nonsurgical and dietary procedures for chronic diseases, convalescent stages, acute diseases, and injuries.	356	32,173	75-200	Yes	$3,300 to $5,500[3]
Private Residence with Professional Home Care	An elder who needs assistance with activities of daily living would require the services of a professional home care agency to maintain maximum independence within their own home	n/a	n/a	n/a	Yes[4]	$1,133[5] plus home expenses
Residential Care Home/ Homes for the Aged	Establishment that furnishes, in single or multiple facilities, food and shelter to two or more persons unrelated to the proprietor and in addition provides services that meet a need beyond the basic provisions of food, shelter, and laundry	119	3,085	15-50	Yes	$1,400 to $1,800

[1] Registration of CCRF required.
[2] Assisted Living Service Agencies must be licensed.
[3] Costs represent range from Medicaid rate to private pay rate.
[4] Professional Home Care Agencies are licenced.
[5] Equals average cost of waiver client enrolled in CHCP.

Source: Assembled by LPR&I staff from Connecticut General Statutes; *Long-term care options in Connecticut*, The Connecticut Association of Residential Care Homes; *Connecticut Health 1994*, Department of Public Health; Data provided by Department of Economic and Community Development

Table V-2 Elderly Housing Options Selected Characteristics

Type	24 Hour Super-vision	24 Hour Nursing Care	3 Meals per Day	Bathing, Dressing Assistance	House-keeping, &Laundry	Super-vision of Medication	Recre-ation Program	Gov't Financial Assist.
Congregate Housing	Yes	No	No[1]	No	Yes[2]	No	No	Yes
Continuing Care Retirement Facilities	Yes	No	No (Extra)	No (Extra)	No (Extra)	No	Yes	No
Managed Residential Communities	Yes	No	Yes	No (Extra)	Yes	No	Yes	No
Nursing Home	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Professional Home Care	No	No	No	Yes	Yes	Partial	No	Yes
Residential Care Homes/ Homes for the Aged	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes

[1] At least one main meal must be served per day to all residents.
[2] Housekeeping is usually available. Laundry facilities may be available in certain facilities.

Source: Assembled by LPR&I staff from Connecticut General Statutes; *Long term care options in Connecticut,* The Connecticut Association of Residential Care Homes; *A Survey of Self-Described Retirement Communities,* Department of Social Services, July 1996.

- ***Housing and Services Model*** - States license facilities that provide assisted living services which are defined by law and in regulation. Theses models require apartment settings and skilled nursing services. Clients who qualify for nursing care are allowed; and

- ***Service Model*** - States certify or license the provider of services rather than the setting in which services are provided.[9]

[9]National Academy for State Health Policy, *Guide to Assisted Living and State Policy,* May 1995, p. 11.

Connecticut uses the third model and licenses assisted living service agencies (ALSA). Although the facility in which the services are provided are not licensed, ALSAs may only provide services in managed residential communities (MRCs), which are defined in state regulation. The ALSA can be a part of the MRC or an independent, contracted agency. MRCs have to notify the health department of their intention to provide assisted living services, but are not licenced by the department.

Services. Under state regulations, MRCs must consist of private residential units that provide a managed group living environment, including housing and services primarily for persons age fifty-five and older. MRCs must provide or arrange for the provision of meal service, laundry service, transportation, housekeeping, home/unit maintenance, and social and recreational activities. ALSAs provide nursing services and assistance with activities of daily living, including supervision of medications, health and wellness counseling, assessment and evaluation, referral services, and provision of care and services to clients whose conditions are chronic and stable. The regulations also address the ALSA's governing body, supervisory and staffing requirements, record keeping, and quality assurance.

Funding. Funding for assisted living is limited. The Connecticut Health and Education Facilities Authority (CHEFA) provides loans for the development of assisted living settings. There is no specific program that subsidizes services for low income residents of assisted living.

Residential care homes. This housing option is also referred to as board and care homes or homes for the aged. Residential care homes are nonmedical community-based living arrangements providing rooms (often semiprivate), shared common areas, meals, protective oversight, and some measure of help with activities of daily living often in a home-like environment. Many of these facilities serve a mixed population of residents, including the aged with physical frailties, persons with chronic mental illness, and persons with developmental disabilities. Many people pay for their room and board with their pensions, Social Security, or other personal funds, since Medicaid and private insurance do not cover costs for residential care homes. In addition, Connecticut has a supplement program that can be applied toward the cost of care. The state pays about half of the cost through the application of an individual's Aid to Aged, Blind, and Disabled payment.

Nursing Facilities

Admission policy. When an individual becomes ill and needs intensive nursing care or lacks family support and is unable to live independently, it often becomes necessary for them to enter a nursing facility. Before an individual can be admitted to a nursing home, the Department of Social Services conducts two types of reviews. In addition, nursing facilities are required by statute to inform all potential admissions about the CHCP and provide them with program information.

Preadmission screening and annual resident review. The Department of Social Services, through the five alternative care unit field offices' performs two types of screening for nursing home admission for all individuals who are 65 or older. For both screens, client information is obtained from either community providers, hospitals, or a nursing facility. In the first screen, the department is responsible for identifying potential nursing home applicants who exhibit characteristics of mental illness and/or mental retardation. Those individuals are then referred to the Department of Mental Health and Addiction Services or the Department of Mental Retardation, who are responsible for determining need for nursing home care or finding a more appropriate placement. This review is known as the Preadmission Screening and Annual Resident Review (PASSAR) and is required in all states by the federal government.

Screening of Medicaid eligible applicants. The other client screen requires the department to review health information on all individuals seeking nursing home placement who are eligible for Medicaid. Individuals aged 65 or older and eligible for Medicaid must also complete a home care request form. The purpose of the review is to determine the need for nursing home care and the feasibility of providing home care. The department reviews the health screen to verify that an individual seeking nursing home placement has sufficient critical needs (defined as deficiencies in activities of daily living) or significant cognitive or behavioral impairments. The department will then authorize admission and Medicaid payment for nursing facility care.

Connecticut nursing facilities. As shown in Table V-3, Connecticut had 356 nursing facilities with 32,173 licensed nursing home beds as of September 30, 1994. Nursing homes are licensed by the Department of Public Health to provide either skilled or rehabilitative care, in either "chronic and convalescent nursing homes (CCNH)," or intermediate care (most commonly characterized as custodial care) in "rest homes with nursing supervision (RHNS)".

Table V-3. Licensed Nursing Facilities as of September 30, 1994.

Type of Facility	*Number*	*Licensed Beds*
Chronic and Convalescent Nursing Homes (CCHN):		
Freestanding CCNH	168	18,827
CCNH with attached RHNS	85	9,081
Total CCNH	253	27,908
Rest Homes with Nursing Supervision (RHNS)		
Freestanding RHNS	18	1,165
RHNS attached to CCNH	85	3,100
Total RHNS	103	4,265

Source: Department of Public Health: Selected data concerning public health program in Connecticut and the health of Connecticut's residents, 1994.

Nursing home services. Nursing facilities provide housing, meals, medical, and nursing care, as well as assistance with personal hygiene and social activities supervised by professionals on a 24-hour basis. Medicaid requires facilities to provide three groups of services:

- skilled nursing care and related services for residents who require medical or nursing care;
- rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or
- health-related care and services which can be made available only through institutionalization.

Medicaid law also requires that nursing facilities provide services and activities that allow residents to attain and maintain their highest practicable physical, mental, and psychosocial well being. These services include nursing and specialized rehabilitative services; medically-related social services; pharmaceutical services; dietary services; an on-going activities program; and routine and emergency dental services.

Scope of services in Connecticut facilities. Table V-4 shows the services provided to a nursing home resident and those available to CHCP clients. It is important to note that while nursing home clients receive most or all of the services available, this is not true for CHCP clients who cannot exceed specific cost caps that limit the amount of services. A major component of nursing home care is room and board and 24-hour nursing care, services which are not provided under CHCP.

The per diem Medicaid rate for nursing home care would not include items or services for a residents convenience. Examples of items and services that may be charged to residents include: telephone, television and radio, personal comfort items, cosmetic and grooming items, and personal clothing.

Expenditures. Figure V-1 shows nursing home expenditures (excluding intermediate care facilities for the mentally retarded) over the last eight fiscal years. The overall increase in expenditures, from FY 89 to FY 96 was 90 percent. The greatest increase occurred in FY 91, when expenditures rose 25 percent; the smallest in FY 96 with only a 2 percent growth rate. In FY 96, the estimated per diem Medicaid reimbursement rate was $109.38, which amounts to $39,924 annually.

Medicaid Nursing home population. The Medicaid nursing home population was estimated at 21,100 for FY 96, a growth of 5,154 in eight years. The year-to-year increase is shown in Table V-5.

Table V-4. Long-Term Care Services Available.	
Connecticut Home Care Program	*Nursing Facility*
Adult Day Health Services	Consultation Services
Care Management	Dietary Services
Chore Services	Laundry Services
Companion Services	Occupational Therapy Services
Elder Foster Care	Personal Care Items and Services
Home Delivered Meals	Physical Therapy Services
Homemaker Services	Recreational Services
Home Health Services: skilled nursing, occupational, physical, and speech therapy	Room and Board
Laundry Services	Routine Lab, Routine X-ray and EKG
Mental Health Counseling Services	Skilled and Rehabilitative Nursing
Personal Emergency Response System (PERS) Services	Social Services
Respite care Services	Speech Therapy Services
Transportation	Standard Nursing Services

Source: LPR&IC Analysis.

Figure V-1. Medicaid Nursing Home Expenditures FY 89 - FY 96

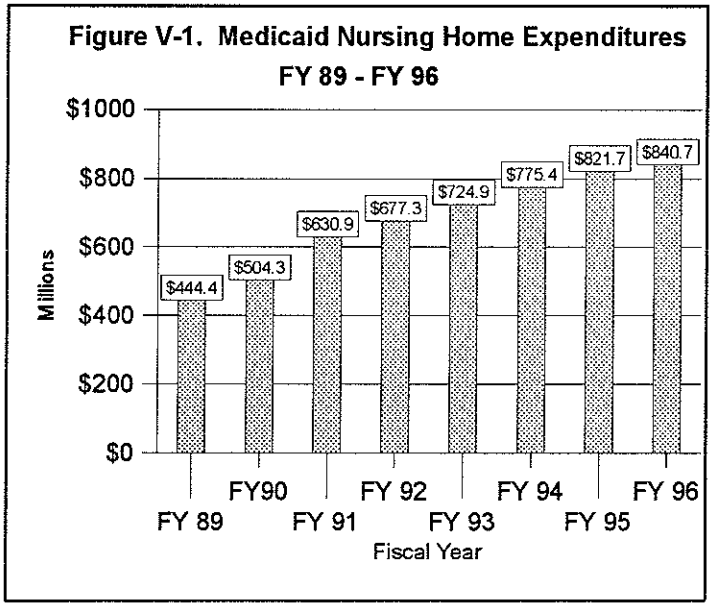


Table V-5. Medicaid Nursing Home Population: 1989 to 1996.		
Fiscal Year	*Average Medicaid Population*	*Percent Change*
FY 89	15,846	--
FY 90	15,999	2.83%
FY 91	17,263	7.32%
FY 92	18,600	7.19%
FY 93	19,334	3.80%
FY 94	20,257	2.18%
FY 95	20,708	1.86%
FY 96 (est.)	21,100	1.86%

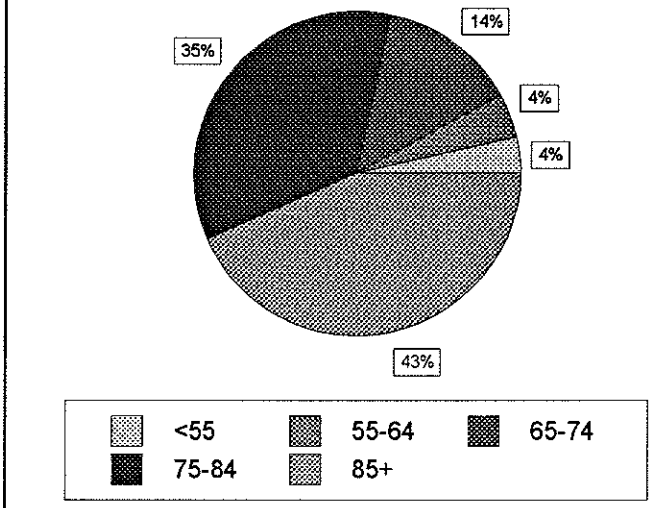
Source: Office of Fiscal Analysis.

Resident Demographics. The Connecticut Public Health Code requires nursing home administrators submit an annual patient roster and census report to the Department of Public Health each year. The roster, a chronological list of patients who resided in a nursing facility between October 1 and September 30 of a given reporting year, contains demographic and health status information about each patient. The analysis below is based on demographic data provided by the Department of Public Health for the 30,381 clients residing in a nursing facility on September 30, 1994.

- *Admissions*. The majority (60 percent) of the nursing home residents had been admitted to a nursing home from a hospital. The next most common admission origin was directly from a home, accounting for 16 percent of all nursing home admissions. Other sources included homes for the aged, veterans administration, and chronic disease hospitals. In addition, the average length of stay is 2.6 years.

- *Age*. There were a total of 30,381 individuals residing in a nursing home on September 30, 1994. As Figure V-2 illustrates, residents aged 85 or older account for 43 percent of the nursing home population. Further, fully 78 percent are at least 75 years old. As noted earlier in this report, individuals aged 85 or more are most likely to need nursing home care.

Figure V-2. Age of Residents



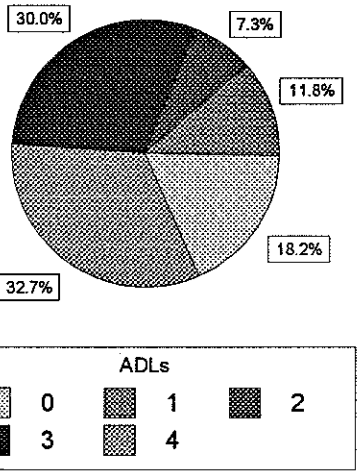
Total Number of residents = 30,381
Source: DPH.

- *Gender*. The state's elderly as a whole and those in nursing homes are predominantly female. However, female residents far outnumber males, representing 74 percent of all nursing home patients. In addition, females account for 84 percent of residents over 85 years old.

- *Race*. The majority of nursing home residents were white (93.3 percent). African-American and Hispanic patients comprised only 5.2 percent and 1.3 percent respectively.

- *ADL and IADL dependencies*. Information on the ADL status of nursing home residents was limited to four measures -- feeding, dressing, ambulation, and transferring. Figure V-3 shows the number of ADL limitations for clients residing in a nursing home on September 30 ,1994. There were 9,894 residents who needed assistance with all four ADLs and 3,560 residents (0.3 percent) had only one ADL deficiency. However, 18.2 percent of total residents had no limitations. Many of those residents are likely to have cognitive or behavioral impairment.

Figure V-3. ADL Statuts of Residents
(September 30, 1994)



Total residents =30,263
Source: DPH

Residents were classified as dependent, sometimes dependent, or independent in the four ADL measures used. Of those clients classified as dependent or independent: 68 percent of all nursing home residents needed assistance with transferring in and out of bed or a chair, 79 percent with dressing, 36 percent with eating, and 66 percent with ambulation. Also, in terms of bladder continence status, almost 50 percent of residents were incontinent or sometimes incontinent.

- *Discharges*. Information is also compiled on all discharges that occurred during FFY 94. There were 36,104 residents discharged. Forty-one percent of patients were discharged to a hospital, 25 percent went home, and 21 percent died.

- *Payment source*. Table V-6 shows the source of payment for nursing home residents on September 30, 1994. The payment source for the majority of residents (66 percent) was Medicaid.

Table V-6. Source of Payment.		
Payment Source	*Number*	*Percent*
Medicaid	*20,053*	*66.0%*
Private	*6,411*	*21.1%*
Medicare	*2,992*	*9.8%*
Out-of-state Medicaid	*520*	*1.7%*
Insurance	*172*	*0.6%*
Other, Unknown	*233*	*0.7%*
Total	*30,381*	*100.0%*

Source: DPH.

KEY POINTS

CHAPTER SIX: THE ELDERLY POPULATION AND POTENTIAL DEMAND FOR LONG-TERM CARE

- There are a total of 468,457 elderly (aged 65 or older) in the state. By 2020, the projected number of elderly will grow to 629,874, representing a 265,014 increase. Given this trend there will be a strong demand for public funds to support long-term care services.

- There is no single source of data that indicates the potential demand for long-term care services and the type of services needed by Connecticut's elder population.

- Of the 52,215 elders in Connecticut estimated to have at least one limitation in activities of daily living (ADL), 46 percent had difficulty in 1 ADL; 34 percent with 2 or 3 ADLs; and 21 percent with 4 or more.

- Age is a major factor associated with ADL limitations -- 34.5 percent of elders aged 85 or more have at least one ADL limitation, but only 5.9 percent of elders aged 65 through 69.

- The demand for CHCP services has increased dramatically since the program began operations in FY 93.

- The program had an average growth rate (new clients minus discharged clients) of 120 clients per month when it was fully open -- which is an indication of demand for program services.

- Due to funding limitations, admission to CHCP was closed in FY 96 and a waiting list for CHCP services was established. As of June 28, 1996, there were 3,154 names placed on the waiting list.

- Intake for the waiver portion was reopened on a limited basis in August 1996, however, the state-funded portion remains closed.

- As of November 30, 1996, there were 1,106 openings available for elders, but only 894 openings had been filled or were scheduled to be filled by DSS.

- In the absence of services, it is likely that some elders have sought nursing home placement, some received services under other publicly funded programs, and others rely on family and friends to provide assistance.

Chapter Six

THE ELDERLY POPULATION AND POTENTIAL DEMAND FOR LONG-TERM CARE SERVICES

The potential demand for long-term care services has important consequences for states. This chapter profiles the elderly population (over 65 years old) both nationally and in Connecticut. The projected growth in Connecticut's elderly population over the next twenty-five years is also discussed. This projection is extremely important because the baby boomer generation (individuals born between 1946 and 1964) is expected to have a major impact on demand for long-term care.

In addition to demographics, estimates of frailty among Connecticut's elder population have also been projected by the program review committee. In the committee's opinion, these estimates should be further refined to determine service demand and used in planning a comprehensive long-term care system. Lastly, CHCP activity is examined to determine the number of elders who have sought admission into the program because of a need for home and community-based services. Together, this information shows the potential demand for long-term care resources and underscores the need to develop a state policy based on the preferences of the population served and the costs of delivery.

National Demographics

Elderly population in the United States. In 1990, there were 31,995,000 Americans aged 65 and over living in the United States. By 2025, the number of individuals aged 65 and older is projected to increase to 60,599,000, representing a 89 percent increase over 1990. In 1990, elderly Americans accounted for 11 percent of the total U.S. population, by 2025, they will account for 18 percent. Finally, as of 1990, individuals aged 85 or older accounted for 1.3 percent of the total population -- by 2025, that age group is projected to increase to 1.9 percent. While comprising a small percentage of the population, the elderly represent a significant cost in long-term care expenditures.

As America's population ages, the demand for public resources, particularly in the areas of social and health services will also increase. Many of these individuals will need long-term care services. Although nursing home

care is used by individuals of all ages, the risk of nursing home placement is greater for the elderly and individuals aged 85 are most likely to need care provided in these settings.[10]

State Demographics

Demographic trends. There are two interesting trends noted in the analysis of the state population demographics below. First, the number of elderly in the state as a proportion of the total state population is increasing. In 1980, people age 65 and older comprised 12 percent of the state population. By 1995, this age group accounted for 14.2 percent and will continue to grow over the next several decades. As a result, unless the pattern with which elders use nursing home services changes or new models for care are adopted, the growth in Connecticut's elderly population will place greater and greater strain on the state budget. The second trend, is the percentage of individuals over 85 years old is growing. Although nursing home care is used by individuals of all ages, the risk of nursing home placement increases for the elderly, and especially individuals aged 85 or older.

State Plan on Aging. The Department of Social Services is responsible for developing a State Plan on Aging. The current plan is valid from October 1, 1995, to September 30, 1997. Statistics contained within the plan portray Connecticut as a relatively old state with census information indicating a median age of 35.6, the fourth highest median age in the country. Although Connecticut ranks 27 in terms of total population, it drops to 18th in terms of population age 65 and older. Connecticut also has the longest life expectancy in New England, with life expectancy at birth in 1987 of 75.1 years, tying Connecticut with Washington state for the 11th longest life expectancy in the country. Life expectancy varies between men and women. As of 1992, life expectancy at birth for American men was 72.3 years while life expectancy for women was 79.0 years, a 6.7 year difference. As a result, the majority of the elderly are women.[11]

Marital status. Figure VI-1 shows the marital status of persons aged 60 or more. Slightly more than half of the elderly in Connecticut were married (57 percent) in 1990. Almost one-third (29 percent) were widowed, while 7 percent of the elderly in Connecticut were single. In addition, more women (41 percent) than men (12 percent) were widowed. The majority of those widowed (83 percent) age 60 or over were women. Given that 43 percent of those over 60 years old do not have a spouse, many of these individuals may lack an informal support system when they become frail since spouses provide much of that support.

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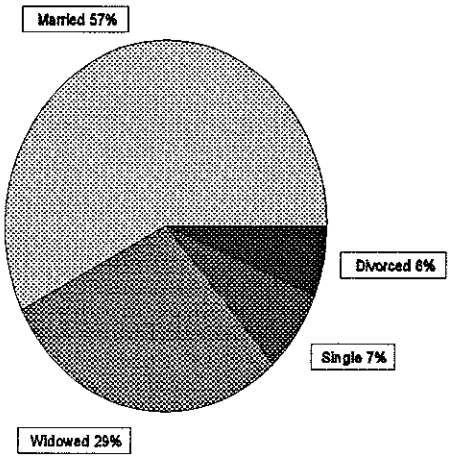
[10]Committee on Ways and Means, U.S. House of Representatives, *Overview of Entitlement Programs*, 1994 Green Book.

[11]Department of Social Services, *State Plan on Aging*, October 1, 1995 to September 30, 1997.

Residence. Thirty-five percent of all elderly women live alone, but only 15 percent of all elderly men live by themselves. The 1990 census found that 27 percent of persons age 65 and over lived by themselves, 55 percent lived in family households as the head of household or spouse, 8 percent lived with families of relatives, 3.5 percent lived with nonrelatives or in some sort of group quarters, and 6.5 percent were in institutions. Of people age 65 and over who live alone, 78 percent are women, the most likely group to need long-term care services.

Figure VI-1. Marital Status of Elders

FY 90



Source: State Plan on Aging.

Income. Income is an important indicator of eligibility and need for publicly financed social and health programs. Table VI-1 shows the distribution of household income in CT for 1989. Fully 56 percent of households over 65 years old had incomes below $25,000 compared to 27.5 percent for all households in the state. The largest percentage of elderly fell in the $15,000 to $24,999 category. However, income is often not the only measure used to determine eligibility for programs. Assets held by individuals also are important in order to establish the level of impoverishment. However, asset information on the population was not available.

Connecticut's elderly population (1995). Table VI-2 shows the distribution of elderly by specific age groups and gender based on 1995 projections calculated by the Office of Policy and Management. Females comprise 61 percent of the total elderly population and 76 percent of those aged 85 and older.

The number of elderly persons aged 75 or older account for 46 percent of the total elderly. The figure shows a sharp decline between the number of individuals who are over 75 years old and the number of individuals over 85 years old, with this age group comprising only 12 percent of the total elderly (over 65) population. Although this would be expected since the incidence of death increases as people age, the number of individuals who are 85 years old or more is important because the need for long-term care services increases significantly for this population.

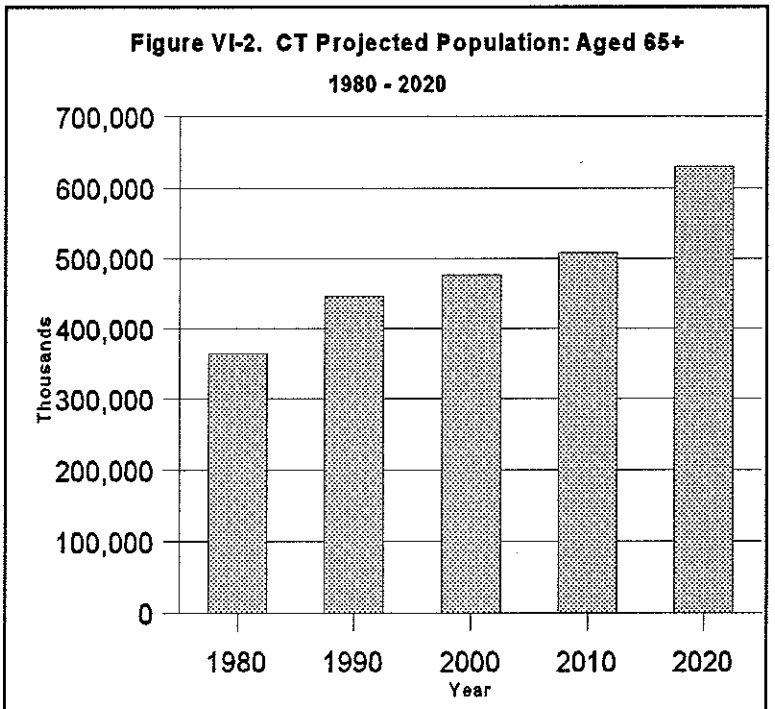
Table VI-1. Distribution of Household Income in CT 1989.				
Income	*65+ Years old*	*Percent*	*All households*	*Percent*
under $5,000	15,476	5.6%	40,314	3.3%
$5,000-$9,999	46,614	16.8%	79,365	6.5%
$10,000-$14,999	36,753	13.2%	67,365	5.5%
$15,000-$24,999	56,158	20.2%	150,389	12.2%
$25,000-$34,999	38,941	14.0%	166,594	13.5%
$35,000-$49,999	35,256	12.7%	232,427	18.9%
$50,000-$74,999	28,098	10.1%	267,244	21.7%
$75,000-$99,999	10,040	3.6%	113,529	9.2%
$100,000 or more	10,499	3.8%	112,646	9.2%
Total	277,835	100.0%	1,229,873	100.0%
Median Income, Householder 65+: $22,135 Median Income, All Households: $42,157				
Source: DSS, State Plan on Aging, based on 1990 Census, Summary Tape File 3A.				

Table VI-2. Elderly in Connecticut by Age Group (1995).			
Age	*Male*	*Female*	*Total*
65-69	61,010	72,924	133,934
70-74	50,389	68,750	119,139
75-79	37,762	59,517	97,279
80-84	21,987	42,245	64,232
85+	13,170	40,703	53,873
Total	184,318	284,139	468,457
CT Population Projections, Series 95.1, Sept. 1995, Office of Policy and Management.			

Potential Demand for Long-Term Care Services

Projected elderly population in Connecticut. The population in Connecticut is gradually aging. The rate of change is not that notable until 2010 when baby boomers enter their mid-60s. In 1980, persons aged 65 or more numbered 364,860, comprising about 12 percent of the state's total population of 3,107,576. In 1990, the Census Bureau counted 445,907 persons aged 65 and over, accounting for 14 percent of the total state population of 3,287,116. By 1995, 14.2 percent of the state population was aged 65 or older, according to population projections developed by the Office of Policy and Management (OPM).

Figure VI-2 shows population projections from 1980 to 2020. By 2020, the projected number of elderly will grow to 629,874. In terms of potential demand for long-term care services the number of elderly will increase by 265,014. Given this trend there will be a strong demand for public funds to support long-term care services.



Source: Connecticut Population Projections Series 95.1, Office of Policy and Management.

Assessing need. Elders become frail due to illness-related factors, general health deterioration, and societal factors such as poverty or social isolation. As mentioned in Chapter One of this report, an individual's need for long-term care is usually measured by assessing limitations in his or her capacity to perform certain daily functions or activities. These measures are called activities of daily living (ADLs). The number of ADLs, as well as an individual's cognitive ability and behavioral status, indicates the degree to which an elder requires long-term care services. The setting where they are delivered, and whether they are delivered formally by providers or informally by family, depends on a variety of other factors including: type of illness and medical supervision needed; availability of family support; client safety issues; client choice; and the total cost of services provided.

Estimating frailty in the elder population. Currently there is no single source of data that indicates the potential demand for long-term care services and the type of services needed by Connecticut's elder population. Although the Department of Social Services is the primary payor and provider (through private contracts) of publicly funded long-term care services, it does not develop estimates of need. The program review committee believes it is important for both policy and program planning purposes to forecast potential need within the long-term care system. Projections would provide some indication as to the number of individuals who may need services and help define the state's role in planning, funding, and delivering long-term care services.

Determining the number of people aged 65 or more with activity limitations living in the population and their unmet needs, and then measuring their potential demand for program services is not a straightforward task. Disability, measured as rates of activity limitation, increases with age and worsening socioeconomic conditions. The analysis below shows the extent of possible demand and highlights the need for the state to define and appropriately fund long-term care options.

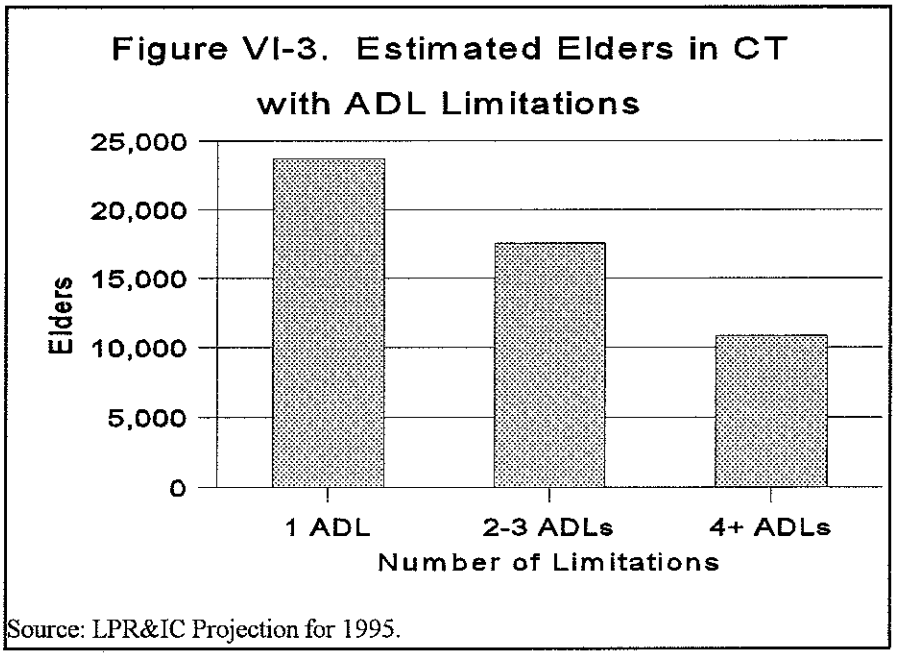
Table VI-3 estimates the percent of disability or frailty among Connecticut's elders using limitations in activities of daily living as a measure for frailty.[12] The projections developed are for elders living in the community and exclude individuals aged 65 or older who reside in nursing homes. Overall, an estimated 11.9 percent (52,215) of elders aged 65 years or more have limitations in at least one ADL. Age is a major factor associated with ADL limitations and the percent of the population with ADL limitations increases substantially with age. There were 13,597 (34.5 percent) of elders aged 85 or more with at least one ADL limitation, but only 5.9 percent of elders aged 65 through 69.

The number of limitations provides an indication of an elder's functional independence. Typically, the more limitations the higher the level of service needed (usually based on the frequency and intensity of services required). Figure VI-3 shows the number of ADL limitations by age group. Of the 52,215 elders estimated to have at least one ADL limitation, 46 percent had difficulty in 1 ADL; 34 percent with 2 or 3 ADLs; and 21 percent with 4 or more. Although elders with limitations in 4 or more ADLs only comprise about 2.5 percent of those in the aged 65 or older population profiled, these elderly most likely need the most intensive level of care. Individuals aged 85 or older accounted for 34 percent of the population who had 4 or more ADLs.

[12]The program review committee's staff developed gross estimates of disability among Connecticut's elderly population. The estimates were derived from age-specific national estimates of disability from the National Medical Expenditure Survey and Connecticut's 1995 elderly population as projected by the Office of Policy and Management and the Nursing Home Registry for 1994.

Table VI-3. Estimates of Need in Connecticut's Noninstitutionalized Elder Population.			
Age	*1995 Estimated Population*	*At Least One ADL*	*Percent of Population*
65-69	132,605	7,824	5.9%
70-74	116,800	9,227	7.9%
75-79	93,193	10,717	11.5%
80-84	58,335	10,850	18.6%
85+	39,412	13,597	34.5%
Total	440,345	52,215	11.9%

Source: LPR&IC Analysis of National Medical Expenditure Survey Data, OPM Projected 1995 Census, 1994 Nursing Home Registry.



Source: LPR&IC Projection for 1995.

Although the analysis presented above provides only gross estimates of frailty among elders, the program review committee believes these types of estimates should be improved in order to better understand the population that may need services. This information then could be used to help predict demand for long-term care services in general; for specific types of services; and for the potential public resources that need to be allocated to provide services.

Connecticut Home Care Program Activity

Program demand. The demand for CHCP services has increased dramatically since the program began operations in FY 93. As reported in Chapter Four, expenditures for the program has also experienced significant increases from $52,773,955 in FY 93 to $84,289,618 in FY 96. Table VI-4 shows the number of clients served and the average cost per client for each of the four years. It is important to note that these figures only provide an unduplicated count of clients within each fiscal year, however, clients may be duplicated across fiscal years. Of the four years the program has been in existence, the greatest number of clients (8,569) received services in FY 95. In FY 96, the department estimated that 8,083 clients received CHCP services, of which 64 percent qualified under the Medicaid waiver and 36 percent under the state-funded.

Table VI-4. Number of Clients Served: FY 93 - FY 96.

Fiscal Year	*State funded*	*Medicaid Waiver*	*Total Clients*	*Cost per Client*
FY 93	3,606	3,417	7,023	$7,515
FY 94	2,368	5,111	7,474	$6,920
FY 95	2,595	5,974	8,569	$7,861
FY 96 (est.)	2,892	5,191	8,083	$10,170

Source: Department of Social Services, Alternate Care Unit.

The rise in the average cost per client is a result of two factors. First, the number of clients served under the waiver program grew from 49 percent in FY 93 to 64 percent in FY 96. The waiver program has the highest cost caps for clients (100 percent of average Medicaid cost in a nursing facility) and therefore, more services are received by each client. The other factor is the cumulative impact of clients served in FY 95. When most of those clients were carried over into FY 96, their care plans were fully implemented and thus, higher costs were incurred.

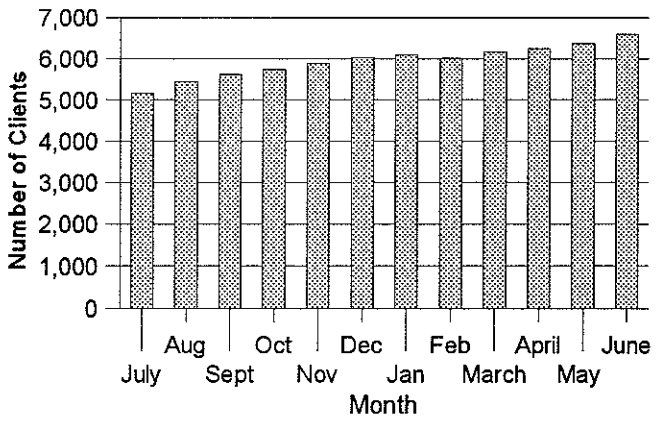
Status of admission. For most of the program's life, admission has been closed for either the state funded or waiver portion of the program or both. Table VI-5 shows the intake status for each of the years the CHCP has been operating. In FY 93 and FY 94 the state-funded portion of the CHCP was closed. FY 95 was the only year that intake was fully open for both the state funded and waiver programs. Again, in FY 96, the waiver program closed on July 24, 1995, and the state-funded program closed on October 10, 1995. Intake recently reopened (August 1, 1996) but only for the waiver program. The state-funded portion of the program remains closed.

Table VI-5. Status of Intake (FY 93 - FY 97).		
Fiscal Year	*State-Funded*	*Waiver*
FY 93	closed	open
FY 94	closed	open
FY 95	open	open
FY 96	closed (10/10/95)	closed (7/24/95)
FY 97	closed	open (limited)

Source: LPR&IC Analysis.

Since admission to both portions of the programs only was open in FY 95, the program review committee selected that year to examine program demand. The growth in clients for FY 95 is shown in Figure VI-4. The number of active clients grew 28 percent from 5,161 on July 1, 1994 to 6,591 on June 30, 1995.

Figure VI-4. Total Clients: FY 95



Source: LPR&IC Analysis.

By analyzing intake and discharge patterns when funds were available and intake open, the growth in clients can be measured. Table VI-6 shows quarterly intake and discharge activity for FY 95. There was a total of 3,272 new clients added to the program in FY 95. However, since 1, 831 clients were discharged from the program, the net number of new clients was 1,441. The number of new, discharged, and real growth in clients varied from quarter to quarter. The first quarter of FY 95 experienced the greatest number of net new clients (452) and the third quarter the least (274).

Table VI-6. Program Activity: FY 95.			
Quarter	*New Clients*	*Discharged Clients*	*Actual Increase in Clients*
1st Qtr.	821	369	452
2nd Qtr.	849	467	382
3rd Qtr.	790	516	274
4th Qtr.	812	479	333
Total	3,272	1,831	1,441

Source: LPR&IC Analysis.

It is clear from Table VI-6 that more clients were admitted to the CHCP than were discharged, resulting in an overall increase in program costs. The program had an average growth rate (new clients minus discharged clients) of 120 clients per month when it was fully open -- which is an indication of demand for program services. However, further planning and research is necessary to determine when the number of potential clients seeking services (demand) would stabilize and equal service availability (supply).

Establishment of a Waiting List for Services

Due to funding limitations, admission to CHCP was closed in FY 96 and a waiting list for CHCP services was established. The waiting list was put into effect on July 24, 1995, for elders potentially eligible for the waiver program and October 10, 1995, for those potentially eligible for the state-funded program. Intake for the waiver portion of the program was reopened on a limited basis in August 1996, however, the state-funded portion remains closed.

Limitations of screening process. The program review committee examined the month-to-month activity of names placed on the waiting list to determine the potential demand for program services. There are two limitations in using the waiting list as a proxy for demand. First, the number of individuals who have their names placed on the list may not represent the entire population of those in need of services. Given the fact that the program has been closed so often, some people probably did not bother to have their names placed on the list at DSS. Second, those who do contact the department and are told there is a waiting list but it is not known when admission will be reopened, may decide not to have their names placed on the list.

Conversely, the list may overrepresent the number of people actually eligible since the department only performed a limited eligibility screen prior to placing a person's name on the

waiting list. A full assessment and evaluation of the client's ability to function in terms of daily activities of living (ADLs) has not yet been performed and therefore, whether a client is actually eligible for the program is unknown.

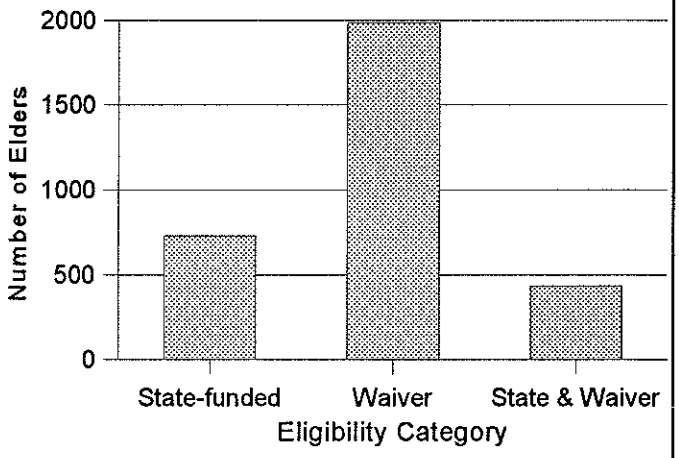
It is important to note that not all clients who pass the screen and are referred to an Access Agency[13] for assessment are eligible for services. In FY 95, there were 5,000 clients who passed the DSS screen and were referred for assessment. Of those assessed, only 3,272 (65 percent) actually became a CHCP client. Thus, if these percentages are applied to the current list of 3,154 elders, 2,050 will be eligible for services, after a full assessment.

Waiting list statistics. There are three categories to which an individual may be assigned based on the three categories of eligibility discussed previously in Chapter Three. The department, when placing names on the list, only determined if a person met the age criteria and financial limits of the program, without establishing functional disability. Persons were assigned based on the financial information provided to department staff. The categories are:

- eligible under the waiver only category;
- eligible for either waiver or state-funded; or
- eligible for the state-funded program only.

Figure VI-5 shows the total number of elders by waiting list category. As of June 28, 1996, there were 3,154 names placed on the list. However, this number includes 536 persons who are already receiving state-funded CHCP services but have been placed on the waiting list because they are Medicaid eligible and may need the higher level of service provided under the waiver program. Elders who contacted the department before the state-funded program closed admission but after the waiver program closed may have been offered state-funded services and their names were placed on the waiting list under the waiver-only

Figure VI-5. Waiting List by Category
As of June 28, 1996

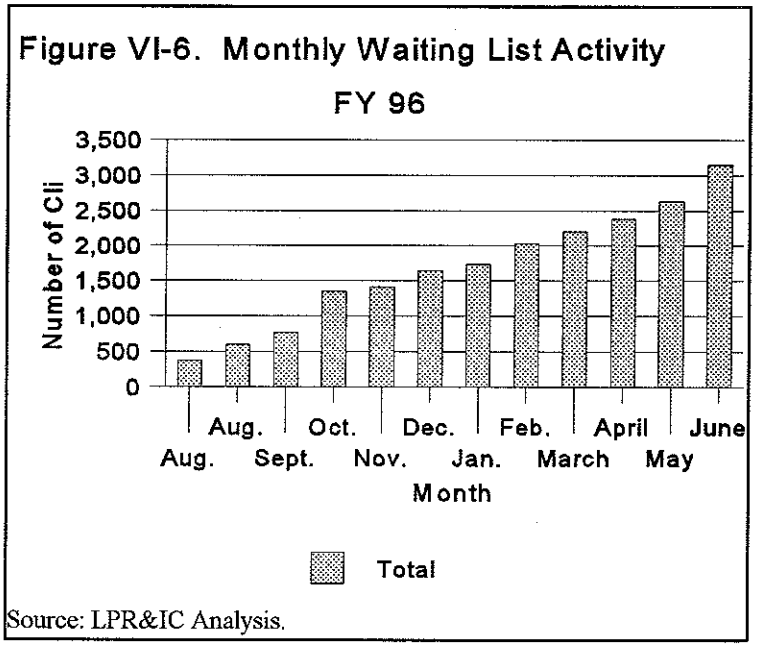


Source: LPR&IC Analysis.

[13]An Access Agency performs all assessments of potential clients and provides care management for those eligible for services.

category. In addition, frail elders already receive state-funded services but need the higher level of services provided under the waiver category, have also been placed on the waiting list for the waiver-only program. Therefore, there are 2,618 elders on the waiting list who are not receiving any home and community-based services funded through CHCP.

Figure VI-6 shows the month-to-month increase in the number of elders placed on the waiting list. The number of people referred to the program on a month-to-month basis varied from a high of 591 in August to a low of 63 in November 1995. The last month shown (June 1996) shows an increase of 20 percent in the number of referral over the previous month. Although the first three months that the waiting list was established received the highest referrals, the list did experience growth in each month examined.



Source: LPR&IC Analysis.

Table VI-7 shows the total number of names on the waiting list by region, the number receiving state-funded CHCP, and the number of people not receiving any CHCP services. The Northcentral Region had the greatest number of elders on the waiting list (33 percent), followed by the Southcentral Region at 20 percent. The Eastern Region had the least number at 13 percent.

Table VI-7. Number of Names on Waiting as of June 30, 1996.

Region	*Total Names*	*Receiving State Services*	*Total not Receiving Any CHCP Services*
Eastern	374	48	326 (13%)
North central	1,003	145	858 (33%)
Northwest	554	72	482 (18%)
South central	636	115	521 (20%)
Southwest	587	156	431 (17%)
Statewide	3,154	536	2,618

Source: DSS, Alternative Care Unit CHCP Waiting List Report for 6/28/96 and LPR&IC Analysis.

Re-opening of admission for Medicaid Waiver program. As previously mentioned, the department reopened admission for the Medicaid waiver program on August 1, 1996. The department allocated 298 openings per month for August, September, and October 1996, and 212 openings per month for the remainder of the fiscal year. The program review committee found of the 1,106 openings available on November 30, 1996, only 486 elders had been offered waiver services. An additional 627 elders were in the process of being screened or assessed. However, since only about 65 percent of elders who are referred for an assessment, actually become eligible for the CHCP, the committee estimated only 408 of the clients would ultimately be offered services. Therefore, of the 1,106 openings available on November 30, only 894 openings were filled or scheduled to be filled, leaving 212 slots (19 percent) empty. Although there is an increasing demand for services and an extensive waiting list, DSS has not been able to fill all the vacant slots available each month.

DSS survey of individuals on the waiting list. In preparation for renewing intake, the department surveyed 1,079 elders on the waiting list to determine if they still need services. They were also asked: 'How have you managed while the Home Care Program for Elders was suspended'? Ten reply categories were developed and the interviewer checked all that applied. The responses are shown in Table VI-8. Since each respondent could select more than one category, there are multiple responses contained in the table. Thus, the total number of responses exceeds the total number of individuals surveyed.

Even though an individual's main support could not be identified, the survey responses do provide insight as to how people in need of long-term care have managed. Of the 1,092 surveyed, 205 were in nursing facilities and an additional 109 elders had died. Most of the respondents (52.7 percent) indicated that family support had helped them manage. Fully 45 percent reported they were receiving state-funded CHCP services. Very few elders received no help (5 percent).

As mentioned previously, several elders are on the list for the waiver category, but are already receiving state-funded services. The table shows 489 of the 1,092 elders responding to the survey stated they had managed by receiving state-funded CHCP services. Therefore, almost all of the 536 elders receiving state-funded CHCP have been contacted. However, there are still 2,062 individuals who need to be contacted to determine if they still are seeking admission into the program. For almost all of these people, state-funded services would not have been available since many of the 3,154 names on the waiting list were placed there after the state-funded program closed.

Conclusions. It is apparent from the above analysis there is unmet need existing among frail elders for home and community-based services offered through CHCP. In the absence of services, it is likely that some elders have sought nursing home placement, some received services under other health programs that are publicly funded, and others rely on family and friends to

provide assistance. Many will put together a patchwork of support so they may remain in the community, as demonstrated by the individuals surveyed. Although many elders who entered a nursing home may have needed the level of care provided in a nursing facility even if CHCP were available, others may have been able to remain at home if services were provided by CHCP.

Table VI-8. Survey Responses of Individuals on CHCP Waiting List.

Categories	*State Total*	*Statewide Percent*
Family Support	576	53%
State-funded	489	45%
Medicare	342	31%
Nursing Facility	205	19%
Medicaid	186	17%
Died	109	10%
Other	116	11%
Private Pay	102	9%
No Help	52	5%
Protective Services	21	2%

Source: DSS, Alternate Care Unit.

Although not all frail elders will need CHCP, development of projections of service demand would provide policymakers with the information needed to make informed decisions about funding levels for this program. Planning and program monitoring are essential ingredients to operating a successful program. The program information presented in this section should be conducted on a regular basis by the department to understand the needs of the clients served and better manage the CHCP program.

KEY POINTS

CHAPTER SEVEN: SURVEY OF DISCHARGE PLANNERS

➢ Hospital discharge planning is one of the key points in the long-term care process and involves a consideration of the options available regarding settings or sources of care before a patient can be discharged from a hospital.

➢ A Legislative Program Review and Investigations Committee survey of hospital discharge staff indicated:

- discharge staff find patients need help immediately, and since the CHCP's intake had been closed, the program was of little help to them when making placement decisions;

- 55 percent of discharge staff stated they referred patients to nursing homes who could be served by the CHCP;

- 10 respondents indicated they would have referred a total of 91 patients within one month to the CHCP if it had been open;

- 91 percent of discharge staff believe there are an inadequate number of home care options available;

- nearly all discharge staff knew about the CHCP, but not all knew about the financial and functional criteria to get into the program or about the services offered; and

- many planners were disappointed with the length of the waiting list and delays in entering the program. However, they strongly supported community-based services and recognized its role it has in preventing or postponing institutionalization.

Chapter Seven

SURVEY OF DISCHARGE PLANNERS

In its evaluation of the CHCP, the committee surveyed hospital social workers, continuing care coordinators, and discharge planners who are involved in discharge planning for frail elderly patients. A listing of discharge staff throughout the state was provided by the Connecticut Hospital Association and Affiliates. Thirty-two surveys were mailed (facilities such as the Connecticut Children's Medical Center were excluded) in October 1996, and 23 (or 72 percent) were returned. The survey contained 18 questions and elicited responses from the discharge staff about their knowledge and use of the program, satisfaction with the CHCP staff, and opinions about home care options. In this chapter, selected results of the survey are highlighted. For the complete survey results and copy of the survey instrument see Appendix C.

Hospital discharge planning is one of the key points in the long-term care process. Hospital discharge staff play a vital role in assisting frail elders and their families in assessing an elder's need for long-term care services and determining where care will be provided. In fact, according to data from the Department of Public Health's Nursing Home Registry, 61 percent of residents in nursing facilities on September 30, 1994, were admitted from a hospital. After an acute episode followed by a hospital stay, many elders often need long-term care assistance. This occurs when an elder experiences a change in health or functional status. Discharge staff must consider the options available about settings or sources of care before a patient can be discharged from the hospital.

Survey Results

Hospital discharge staff were surveyed about the availability of long-term care options for frail elders being discharged into the community. The responses indicate:

- discharge staff find patients need help immediately, and since the CHCP's intake status had been closed, the program is of little help to them when making placement decisions;
- fifty-five percent of discharge staff stated they had referred patients to nursing homes who they believed could be served by the CHCP;

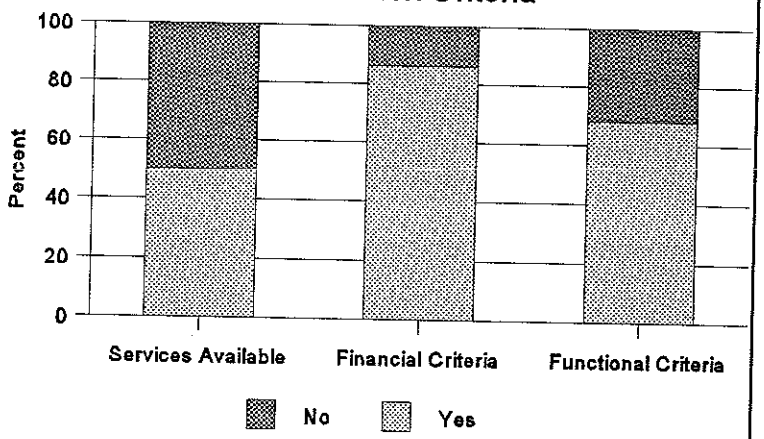
- discharge staff overwhelmingly (91 percent) believe there are an inadequate number of home care options available; and
- over 95 percent of survey respondents believed community-based services play an important role in preventing or postponing institutionalization.

The lack of funding clearly affects accessability to the CHCP and influences the availability of a continuum of long-term care services. The responses underscore the fact that choices in one part of the long-term care system will impact other parts. The discharge staff, for example, were asked to identify the number of patients they would have referred in the last month if the CHCP were open. Ten respondents indicated a total of 91 patients would have been referred over the one month period. The range from individual surveys went from two to 30. Furthermore, the survey asked them to identify what the types of additional services are needed. The top two choices selected were "supportive housing" and "home care". The third highest selection for additional options was "other". This selection included suggestions for additional specific community-based services (companions, homemakers), specific supportive housing models (assisted living), and CHCP program changes (change eligibility criteria, quicker admission, extend hours). The remainder of the survey concerned specific aspects of the CHCP as discussed below.

Knowledge of the Connecticut Home Care Program. Almost all of the survey respondents (96 percent) said they were familiar with the CHCP program. However, when asked specific questions about the program's services and admission criteria, differing levels of knowledge were reported as depicted in Figure VII-1.

Half of the survey respondents did not know all the home and community-based services available under the program. Nearly 14 percent of the discharge staff did not know the financial criteria to get into the program, while almost 32 percent did not know the functional criteria. DSS does not publicize the program's functional criteria because of concerns that community providers may slant the reporting of a patient's initial health information to gain admittance to the program. Therefore, it is not unexpected

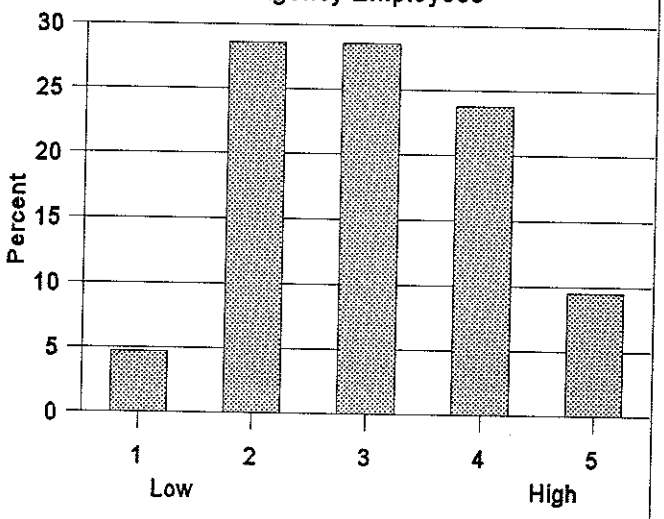
Figure VII-1. Knowledge of CHCP Services and Admission Criteria



Source: LPR&IC Survey of Discharge Planners, 1996

Staff interaction and communication. The discharge staff were surveyed about the quality of the interaction with program staff and about information they receive concerning the program. Respondents were asked to rate their satisfaction with their contact with the CHCP and Access Agency employees on a five point scale (i.e., one is "low" and five is "high"). The responses were fairly evenly split in their opinions as shown in Figure VII-2. One-third rated their satisfaction as low (either one or two on the scale) and one-third rated it high (four or five on the scale). Approximately 29 percent rated their satisfaction in the middle (5 percent found the question to be not applicable).

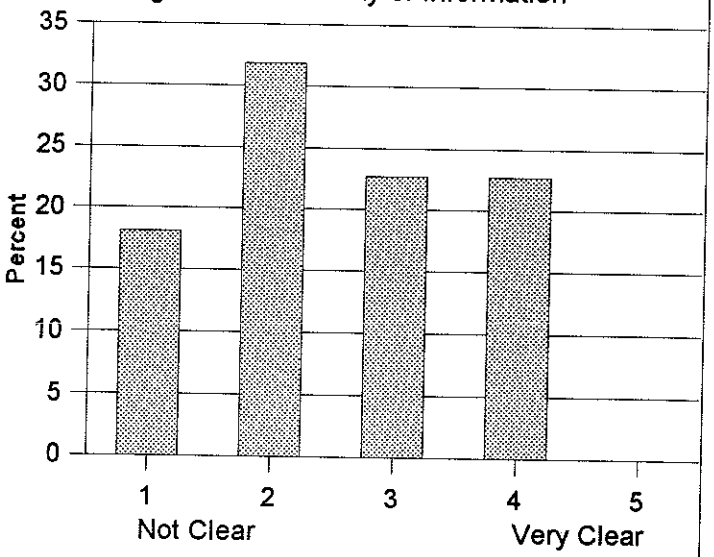
Figure VII-2. Satisfaction with CHCP and Access Agency Employees



Source: LPR&IC Survey of Discharge Planners, 1996.

The discharge staff noted the communication they received from DSS about the program. Specifically, they were asked to assess on a scale from one ("not clear") to five ("very clear") the information provided about the program. Figure VII-3 shows half of the respondents rated the information clarity at the lower end of the scale. Nearly 23 percent rated its clarity in the middle, while the same ratio (23 percent) rated it at the second highest point on the scale. None of the respondents surveyed said it was "very clear".

Figure VII-3. Clarity of Information



Source: LPR&IC Survey of Discharge Planners, 1996.

Similarly, another response in the survey question suggests that discharge planners are not kept well informed by the department. When asked if they had been notified of the reopening of admission to the waiver portion of the program, only 38 percent responded yes. The program review committee is unsure why some planners were notified and other were not. However, all planners should be kept informed of the program's intake status.

Referrals to CHCP. The committee also surveyed discharge staff on whether they made referrals to the program. If they had not, six reply categories were provided on the survey to indicate the reasons why not. Multiple responses were allowed.

Thirty-eight percent of the respondents indicated they had not referred patients to the CHCP. The top two reasons given for not referring elders were: "waiting list was in place and patient needed services immediately" and "other". The "other" response included comments on the need for short-term rehabilitation, the length of the waiting lists, and not enough information about the program and its intake status. The next most frequent response was that it "was too difficult or time consuming to refer."

Sixty-two percent of the discharge staff indicated they had, at some time, made referrals to the program. However, only ten respondents had made a total of 240 referrals within the last three years. Of those who made referrals, the range on individual surveys was from three to 100 resulting an overall average of 24 referrals per respondent.

Suggested improvements. The last two questions on the survey were open ended and asked respondents to identify specific problems they experienced with CHCP and provide comments or any other suggestions about improving home care in Connecticut. The responses were divided into three broad categories.

- *Access to the program.* Several planner's comments expressed frustration with their inability to rely on CHCP to be a regular resource for frail elders. The waiting list was cited as an obvious impediment along with the lack of immediate availability of services and the need for additional services. One discharge planner wrote she was put in a very unfortunate situation by showing people the forms, getting patients' hopes up, and knowing they may not get services.

- *Care management.* The services provided by the Access Agencies were also criticized. These criticisms included instances of clients receiving inappropriate care, case managers' lack of attention to clients' situation, duplication of assessment services, high case loads, and a lack of coordination among the clients' providers.

- *Communication with the CHCP.* Many discharge planners felt they were not adequately informed about what the program had to offer and were not kept up to date with the current intake status. Several cited the lack of flexibility in the program's hours as a problem. Lack of feedback about the program was also noted. Many discharge planners wanted to hear about some of the success stories and know about program statistics. Finally, better communication with case managers in the Access Agencies was suggested.

It should be noted not all the comments were negative. Some of the respondents pointed out that while they may have criticisms with the way some aspects of the program are handled, they support the concept of a home care program. They noted CHCP provides an important opportunity for elders to remain in the community and independent for as long as possible.

Summary. Hospital discharge planners are an important resource for elders and their families trying to make long-term care arrangements. The program review committee's survey of hospital discharge staff underscored many themes that are part of this study. The planners indicated the communication with the program needs to be improved, they would like to be better informed about the services offered, and kept abreast of the program's intake status. They expressed disappointment with the length of the waiting list and delays with entering the program. However, they also indicated strong support for community-based services and recognized the important role it has in preventing or postponing institutionalization. In addition, the discharge planners noted the need for and relationship between a variety of long-term care options for the elderly.

KEY POINTS

CHAPTER EIGHT: FINDINGS AND RECOMMENDATIONS

- The state does not have an adequate long-term care policy addressing the needs of the elderly.

- A fragmented governmental structure is responsible for planning, funding, and overseeing home and community-based care, supportive housing arrangements, and care provided in nursing homes. No one agency is responsible for connecting the various components of the long-term care system and establishing a long-term care plan that describes the state's role in serving the needs of the frail elderly.

- DSS made two significant substantive changes to the CHCP Medicaid Waiver without first reporting and obtaining legislative input as required by law.

- DSS has not established and maintained an effective internal control structure over the CHCP, resulting in significant program weaknesses.

  - CHCP's management information system does not meet the needs of the program and limits the department's ability to collect, analyze, and interpret program information.

  - Significant weaknesses exist in the procedures followed by the department in program planning and fiscal monitoring.

  - The department does not verify the accuracy of state-funded clients' financial statements.

  - The department cannot report on the amount it collects through recoupment efforts from CHCP clients.

- The department does not maintain a formal quality assurance system to systematically oversee the CHCP.

- The department does not have any formal strategy to keep potential referral sources informed about the CHCP.

- The Older Americans Act formula provides an appropriate method to target elders and an equitable distribution of program openings among regions.

Chapter Eight

FINDINGS AND RECOMMENDATIONS

The program review committee found the state does not have an adequate long-term care policy addressing the needs of the elderly. Despite the public's preference for home and community-based services or supportive housing arrangements, long-term care dollars are overwhelmingly spent for residential nursing home care. Many older persons who need some assistance, but without extensive medical supervision, do not have access or cannot afford other long-term care options. In the opinion of the committee, the state needs to lead the way in establishing a continuum of long-term care options focused on providing an appropriate level of service, controlling expenditures, and assisting elders to remain in their homes and community.

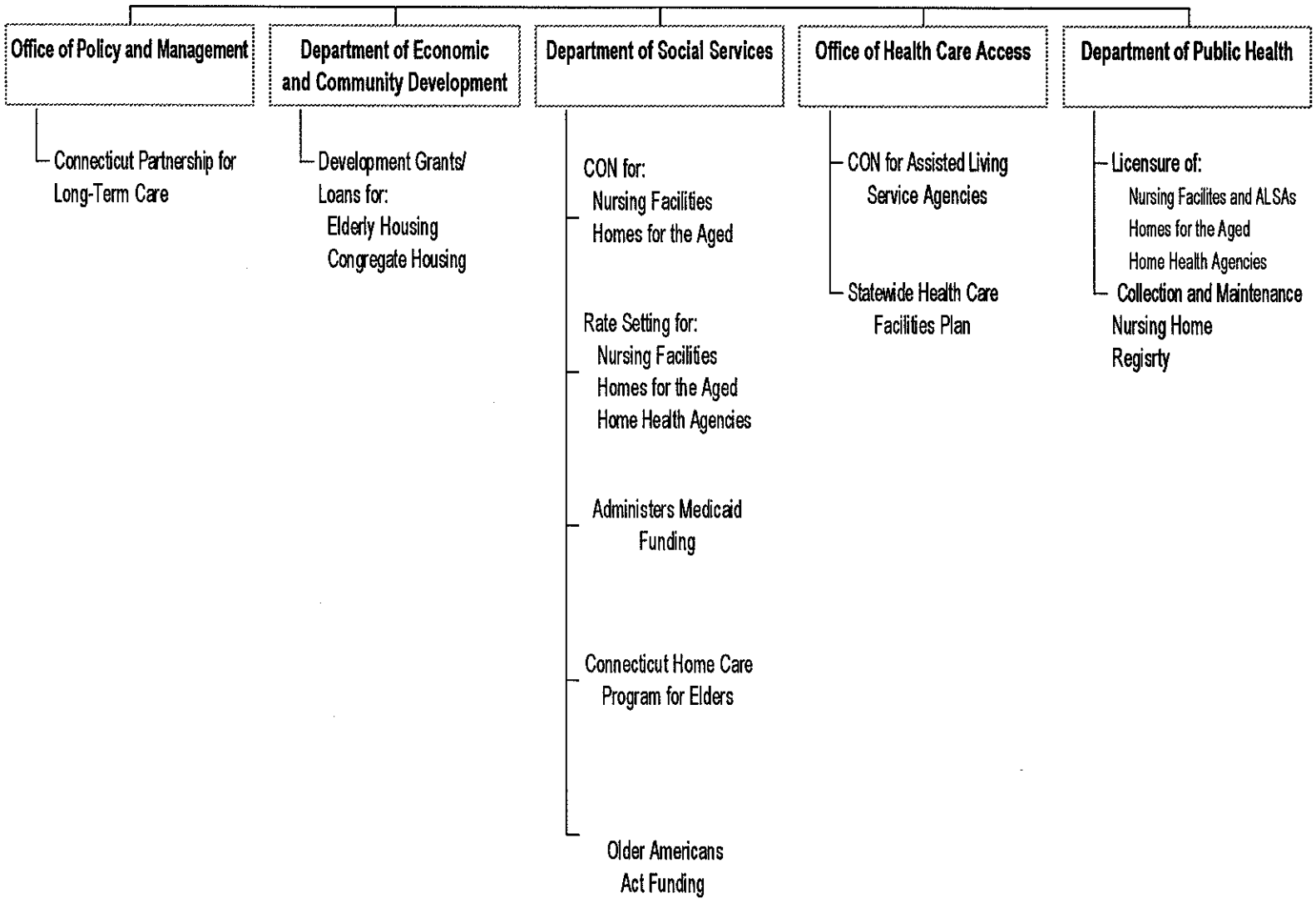
The first recommendation in this report relates to the lack of an overall policy on long-term care due to the fragmentation among governmental agencies and the absence of system-wide planning. The remainder of the recommendations involve the funding and management of the Connecticut Home Care Program. These recommendations are aimed at adequately tracking clients use of services and projecting future program demand so the legislature has sufficient information to make funding decisions.

Long-Term Care Policy Development

The program review committee found a fragmented governmental structure responsible for planning, funding, and overseeing home and community-based care, supportive housing arrangements, and care provided in nursing homes. Long-term care options have often been developed with separate and distinct polices established for nursing homes, supportive housing, and home and community-based care without integration among the three levels of service. Further, compounding this fragmentation is the fact no one agency is responsible for connecting the various components of the long-term care system and establishing a long-term care plan that describes the state's role in serving the needs of the frail elderly.

Long-term care responsibilities. Figure VIII-1 shows the responsibilities of the four state agencies in relation to long-term care issues. The Department of Social Services, as the state's primary human service agency, administers the Connecticut Home Care Program, oversees the distribution of funds under the Older Americans Act, and is responsible for the certificate of need (CON) process for determining the need for new beds

Figure VIII-1. Responsibilities of State Agencies Involved in Long-Term Care



in nursing homes and homes for the aged (but not for assisted living services agencies which is done by another agency). DSS is also responsible for providing nursing home services through the Medicaid budget. In addition, this department sets rates for nursing facilities, homes for the aged, and home health care agencies. Currently, the Department of Public Health is responsible for licensing all nursing facilities, home health agencies, assisted living services agencies, and homes for the aged. The department also collects and maintains demographic information on nursing home residents through the Nursing Home Registry.

The Office of Health Care Access issues CON's for assisted living services agencies (ALSAs) and is charged with establishing and maintaining a statewide health care facilities plan which includes an ongoing evaluation of a health care facility utilization. The Department of Economic and Community Development provides grants and/or loans to eligible developers for the development of elderly housing. In addition, the Congregate Housing for the Elderly Program provides funding to eligible developers for congregate facilities for the frail elderly. Finally, the Office of Policy and Management is responsible for coordinating the Connecticut Partnership for Long-Term Care, a program combining private insurance and Medicaid funds to finance long-term care (for a complete program description see Appendix D).

Moratorium on nursing home beds. The certificiate of need moratorium on nursing home beds established in 1991, is scheduled to remain in effect until 2002. As the number of beds remains constant and the percent of elderly needing long-term care services increases, other options such as adult day care, home and community-based care, and assisted living will need to be provided. Both the Nursing Home Task Force and the Congregate Housing Task Force, established during the 1996 legislative session, have recognized the need to develop and implement a coherent long-term care policy.

A long-term care plan should identify the potential providers, users, mix of services, and costs of the system. Serious consideration needs to be given to how the system will be organized, the responsibilities of each state agency, and how information will be compiled and reported. Next, funding decisions must be made concerning what to provide, how much each program will receive, and who will be eligible for services. Finally, cost containment strategies to control the use of services (such as certificate of need processes) must be determined. The interrelationship among the various long-term care components needs to be better understood, identified, and policy options addressed. **Therefore, the program review committee recommends:**

> **An interagency committee consisting of members of the Department of Social Services, the Department of Public Health, the Office of Health Care Access, and the Department of Economic and Community Development, appointed by the commissioners of each agency, and a member of the Office of Policy and Management appointed by the secretary shall be established. The purpose of the committee will be to exchange information on long-term**

care issues, ensure coordinated policy development, and establish a long-term care plan. The plan shall integrate all three major components of the long-term care system including home and community-based services; supportive housing arrangements, and nursing facilities.

The Department of Social Services shall be lead agency and develop the long-term care plan, in conjunction with the Department of Public Health, the Office of Health Care Access, and the Department of Community and Economic Development. The plan shall include:

- **a vision for the long-term care system;**
- **the number of current user of services;**
- **client demographics by service type;**
- **the current costs of the system;**
- **forecasts of future demand for services;**
- **the type of services available and the amount needed to meet demand;**
- **projected system costs; and**
- **strategies to promote the Partnership for Long-term Care Program.**

The plan shall identify the resources needed to accomplish the goals, the funding sources available, and the number and types of providers needed to deliver services. The plan shall consider and describe the expected impact of changes in one component on the other components.

Submission of the plan shall coincide with the biennial budget process, except for the first year of submission, which shall be February 4, 1998.

The plan shall be submitted to legislative committees having specific interest or jurisdiction over this subject matter.

Integrated long-term care policies are aimed at developing a continuum of care and allocating resources. Given the increasing pressures of funding and need for service, a system-wide approach is required that will assist in determining how best to allocate resources. Development of an interagency committee will facilitate coordination among state agencies responsible for providing long-term care. Information exists among the Department of Social Services, the Department of Public Health, the Office of Health Care Access, and the Department of Economic and Community Development that would provide a more complete picture of the future supply and demand for long-term care services. Also, the state needs to develop strategies to actively promote the Partnership for Long-Term Care Program, so the burden of paying for long-term care is shared by individuals with private insurance.

The Department of Social Services is currently developing a research and demonstration (1115a) Medicaid waiver that would provide managed care for the elderly and disabled through Integrated Service Networks (ISNs), entities that do not currently exist in the state. The ISNs would be responsible for integrating primary, acute, and long-term care services to those eligible for both Medicaid and Medicare benefits. These changes will have important implications for the entire health care delivery system among the elderly, and all state agencies playing a major role in delivering long-term care services need to establish a coordinated policy.

CHCP Waiver Development

Medicaid waiver requirements. As previously outlined, the Department of Social Services operates one portion of the CHCP under a Medicaid waiver. The waiver allows states to go beyond Medicaid rules and provide for broader eligibility criteria. The waiver also allows the provision of community-based services (such as adult day care, companion, and homemaker), in addition to the home health services that are traditionally provided under Medicaid alone. In addition, the waiver allows states to limit its fiscal liability by specifying the number of slots that will be funded for each of the five years. Under the waiver, the state may serve as many clients as it wishes as long as it can prove to HCFA the program is cost neutral.

Cost neutrality. The Health Care Financing Administration (HCFA) requires that the average per capita expenditures under the waiver not exceed the average nursing home charges that would have been paid had the waiver not been granted. The department develops multi-year projections based on the number of clients it intends to serve and the cost of providing services. The projections are done to demonstrate the cost-effectiveness of the waiver and are used to establish upper limits. An amendment must be filed by the department if the cost-effectiveness formula changes, which can occur if the state anticipates serving more or less clients than it stated on its waiver application. The state's eligibility criteria for the waiver program must match that to nursing facilities and therefore, a state cannot spend more on a home care client than it would have if the client was in a nursing home.

Connecticut's current waiver period. The Department submitted its application for renewal of the CHCP waiver on March 31, 1995, and it was approved by HCFA June 23, 1995. The waiver covers the period from FY 96 through FY 2000. DSS originally estimated in the waiver it would serve 6,885 clients in FY 96 , however it filed an amendment to its waiver on July 24, 1995, and reduced the estimate to 6,011.

Renewal of the Medicaid waiver application. *The program review committee found DSS made two significant substantive changes to the elder home care (CHCP) Medicaid waiver without first reporting and obtaining legislative input as required by law.* These changes were significant because they ultimately resulted in limiting the number of elders served under the waiver portion of the program. First, expenditures for the waiver portion of CHCP were limited

in FY 96 and FY 97 to a 5 percent expenditure growth over FY 95 expenditures. Inconsistent explanations were provided to the committee's staff by DSS surrounding the imposition of the 5 percent spending cap. Although the department had stated the legislature imposed the 5 percent cost cap during the FY 95 legislative session, the committee's staff found the waiver renewal application submitted in March 1995 contained the 5 percent limit. The legislature did not pass the budget until the end of May 1995, over a month after the renewal application was submitted to the federal government.

Second, the department is statutorily required to submit all federal waivers of any assistance program to the Appropriations committee and the Human Services Committee, per C.G.S. 17b-8(a), prior to the submission of the application to the federal government, except those pertaining to routine operational issues. *The program review committee found neither the renewal application, nor a subsequent amendment that decreased the number of clients to be served, were submitted to the legislative committees, as required by the statute.*

Program status. Until FY 96 when admission to the waiver program was closed, the department served all who qualified for home and community-based services under the waiver. In response to questions from the committee's staff, DSS stated in a letter dated May 15, 1996, that:

> "the program budget for the waiver was limited for the first time in FY 96 through a five percent growth cap established in the Appropriations Act... This limited the expenditures for the waiver community based services to $28.8 million and limited the home health expenditures for waiver clients to $29.6 million. However, even though we established a waiting list in the first month of FY 96, our fiscal staff project that we will overspend this budget by approximately $8 million..." (For complete text of DSS response see Appendix E).

The program review committee's staff reviewed the Appropriations Act (Special Act 95-12) and found no 5 percent expenditure cap placed on CHCP. After the committee's staff requested an explanation, DSS stated in a letter dated October 22, 1996, that:

> "The Governor's recommended budget originally included the savings associated with the restructuring of the waiver program. This recommendation was approved by the General Assembly through the adoption of the Governor's recommendation in the Appropriations Act. It should be noted that the 5 percent cap is not in statute. It was included as a budget option and incorporated into the budget as referenced in the OFA budget book. Since that time it has been viewed as the policy guiding program growth... In order to maintain continuity of the elder home care waiver, the department submitted the renewal request to HCFA on March 31, 1995, prior to the passage of the 1995 Appropriations Act." (See Appendix F for complete DSS response).

The program review committee's staff found the General Assembly did not pass the appropriations act (Special Act 95-12) until the end of May 1995, more than a month after the 5 percent limit was established by the department, as part of the waiver submission to HCFA. Thus, DSS provided the impetus for the spending cap with little input from the legislature. Additionally, an examination of the Governor's Recommended Budget (FY 95-97) also found no specific proposal for a 5 percent growth cap on the program. Instead, the budget referenced savings associated with restructuring the waiver program and making revisions to case management. These recommendations were passed under Public Act 95-160 but related to the establishment of the Access Agencies and repealing licensure of Coordination, Assessment, and Monitoring (CAM) agencies to obtain program savings.

The program review committee is disturbed by the apparent inconsistencies in the department's explanation. Given the legislature did not impose a statutory provision through the appropriations process that limited expenditures in the waiver portion of CHCP, **the program review committee recommends:**

> **The 5 percent expenditure cap limiting growth in the Medicaid waiver program imposed by DSS be removed.**

In addition, although the cap was established only for FY 96 and FY 97, spending projections developed by the department's fiscal office continue the cap through FY 99. A decision on the level of expenditures for the program should be made by the legislature through the appropriations process. Although the committee is aware the department was concerned over program costs due to heavy demand for services, the department should have followed the appropriate process. In addition, this highlights the need for an overall long-term care plan as recommended by the committee so decisions about funding are made in the broader context of long-term care options and with legislative participation and oversight.

Statutory notification of federal waiver submissions. The program review committee also found the department was in violation of Connecticut General Statutes 17b-8(a) when it submitted its waiver without legislative oversight. The statute requires the commissioner of social services to submit an application for a federal waiver of any assistance program, except those pertaining to routine operational issues, to the appropriations and human services committees prior to submission to the federal government. Those committees have 15 days to advise the commissioner of their approval, denial, or modifications, if any, of the application. The committee's staff found neither the waiver nor an amendment to the waiver was submitted to the Appropriations or Human Services Committees for their review. Responding to the committee's staff request for an explanation, the department stated:

> "... C.G.S. Section 17b-8 specifically exempts "routine operational issues" from the mandate for the department to report on federal waiver applications. When

the waiver renewal process involves no substantive changes, the department has understood this to be a routine function... The amendment to the waiver submitted to reduce the caseload (in an attempt to comply with the five percent cap) was sent to the General Assembly on September 22, 1995."

The department never submitted the application for the waiver renewal and did not submit the waiver amendment to the two legislative committees until September 22, 1995, even though it was submitted to HCFA on July 24, 1995. In the opinion of the committee, changes to the waiver involved substantial policy decisions, both in terms of funding and the number of elders that would be provided services. These committees should have been given the opportunity to peruse the waiver, as required by the statute, prior to its submission to the federal government. The program review committee believes the statute needs to be clarified and **therefore recommend:**

C.G.S. sec. 17b-8(a) shall be amended as follows: routine operational issues shall not include waiver renewal applications or amendments to existing waivers that alter program scope, funding, or the number of clients to be served.

CHCP Management Controls

Purpose of management controls. Effective management controls are essential in achieving the proper conduct of a governmental agency. Management controls consist of an agency's methods, policies, and procedures for defining internal work processes, for meeting its operational goals and objectives, and for ensuring compliance with laws and regulations. Controls are also intended to ensure that reliable data are obtained, maintained, and fairly disclosed in reports.[14]

Management controls assist an organization in preventing undesired and unintended actions. Moreover, controls aid decision makers, at all levels, to understand program operations and assess the degree to which a program is meeting its mandated goals.

DSS exhibits management control deficiencies. *DSS management has not established and maintained an effective internal control structure over the CHCP, resulting in significant program weaknesses.* Discussed below are some of the problems with the management information system, program monitoring, and the quality assurance system that need to be addressed to establish a stronger management control environment.

[14] General Accounting Office, *Government Auditing Standards : 1994 Revision,* (Washington D.C. 1994), pp 77-78.

Management Information System (MIS). A basic principle guiding the development of any MIS is the requirement the system produce all essential information to management in a readily usable format. MIS reports allow management to monitor the performance of the organization, evaluate any deviations from expected or desired results, identify necessary improvements, and implement corrective actions in a timely manner. *The program review committee found CHCP's management information system does not meet the needs of the program and limits the department's ability to collect, analyze, and interpret program information.*

DSS databases. The committee acknowledges the severe limitations imposed by the two mainframe systems used by DSS, the Eligibility Management Systems (EMS) and the Medicaid Management Information System (MMIS). These systems are designed for eligibility determination and claims processing and not program evaluation. However, other avenues are available to the CHCP to analyze client and cost information to enhance program management.

The committee found little independent analysis of client data performed by the department because of inadequate MIS support in the central office and too much reliance for data on outside contractors. Although Access Agencies (and formally the Coordination, Assessment, and Monitoring agency) collect a considerable amount of data about CHCP clients and the services used by them, only in the last year has DSS established a procedure for receiving raw client data from the agencies. The data, consisting of information gathered during client assessments and contained within the clients plan of care, could greatly assist the department in program planning and monitoring. Furthermore, no compatible software requirements were established for the three separate Access Agencies to facilitate uniform data transfer and provide the department with an enhanced ability to analyze the information. The program's analysis capacity, therefore, is only in its formative stage, in this the fourth year of the CHCP.

MIS reporting and data exchange. Another weakness in the MIS is present in the relationship between the Access Agencies, DSS central office, and DSS field offices. *The committee's staff visited each of the five alternate care field offices and found deficiencies in the method of exchange and reporting of basic information. These include:*

- *The intake and monitoring process is largely paper driven. Although field office staff are responsible for some client oversight, the offices are not networked with the Access Agencies and do not share in the technological benefits that may accrue from being physically co-located. A networked system would allow for a seamless exchange of vital information;*

- *Even though the field offices have recently received some personnel computers, alternate care staff have unanimously cited a lack of computers and insufficient computer training as a deficiency;*

- *Personnel in both the department's central office and the field offices had difficulty with interpreting aggregated waiting list data. The information was collected from each individual field office's waiting list but DSS staff had difficulty explaining how to read the report and the report contained inaccurate data; and*

- *The Access Agencies have also reported inconsistencies between client information they maintain and data DSS reports.*

The program review committee believes the department needs to strengthen its MIS in order to generate cost and client information that will allow for better program planning, management, and monitoring. **Therefore, the program review committee recommends:**

DSS shall streamline and redesign databases to establish a reliable data system that captures client costs, utilization, and demographics. The department shall also establish a method to regularly audit the reliability of Access Agency data.

In addition, a review of computer and training needs in the field offices should be conducted and appropriate measures should be taken to ensure personnel have the tools and knowledge to effectively do their job. The department shall explore the feasibility of developing an on-line capability with the co-located Access Agencies and develop compatible software standards that allow for a smooth merger of data from the three separate providers of care management.

In developing its MIS capabilities, the department will enhance its own capacity to analyze client data and minimize its reliance on contractor provided analysis. These actions should improve the department's ability to monitor and correct any deficiencies in program performance. Further, regular MIS reports should allow staff at all levels to understand program operations and focus on improving the processes of care.

Program planning and fiscal monitoring. *The committee found significant weaknesses in the procedures followed by the department in the area of program planning and fiscal monitoring.* Planning requires an agency to articulate the nature of a problem, the goals to address the problem, and the methods and rationale used to achieve those goals. Monitoring program activities is a closely related function which allows the agency to compare its planned objectives with its actual accomplishments.

Planning and monitoring deficiencies have plagued both the waiver and state-funded portions of the program. As previously discussed, the department implemented a 5 percent

growth cap over the waiver portion of the program in FY 96 which resulted in the establishment of a waiting list for the first time for this part of the program. The focus of this section is on the state-funded portion of the program, which turned back part of its appropriation in FY 95, while demand for the program was increasing, resulting in the establishment of waiting lists.

State-funded portion. For FY 95, the department asked for and received increased funding for the state-funded portion of the program. Appropriations increased from $8.2 million in FY 94 to $15.7 million in FY 95. However, the department only expended $10.9 million. Consequently, funding was reduced in the next fiscal year. This resulted in the institution of a waiting list in October 1995 for the state-funded portion of the program so as to not overspend its FY 96 appropriation.

The department's inability to forecast and monitor on a short term basis lies at the heart of the difficulty during FY 95. The department's estimate for FY 95 assumed it would serve the new state-funded clients for the entire year and did not account for the cumulative increase in clients. Hence, when the funding was needed the following fiscal year the department did not know how much it needed and received less than what was required to continue admission to the program. (See Appendix G for DSS' complete explanation).

It is evident the CHCP planning and monitoring processes are inadequate. While the department publishes an annual report, it only summarizes basic information about the program and does not identify goals or forecast demand. The program has nearly completed its next fiscal year before the previous fiscal year's results are complied and made available. The department needs to develop its capacity to better assess and forecast costs and client demand for services. **Therefore, the program review committee recommends:**

the department review and strengthen its internal program planning and monitoring process. As part of that effort, the department should establish a clear mission for the program and develop a biennial spending plan. The plan should:

- **establish annual goals for the program;**
- **forecast client demand;**
- **track utilization; and**
- **identify revenue sources and anticipated expenditures.**

The department shall include in the spending plan a monitoring system that would ensure a comparison of projected annual expenditures and client utilization with actual appropriations, expenditures, and client usage. In addition, the system should include an examination of program costs and clients served by region.

State-funded client's financial statements. In addition to inadequate forecasting and budget monitoring practices, the committee found inadequate procedures in two other areas related to fiscal monitoring and reporting -- client income verification and recoupment. The first involves the intake process. During the intake process applicants are asked to provide financial and health related information to DSS to determine eligibility for the CHCP. The department does not make any attempt to verify the accuracy of state-funded clients' financial statements. Medicaid eligible recipient information is verified by a DSS district office. However, state-funded clients only fill out a self-declaration form. **Therefore, the program review committee recommends:**

> **the department select a random number of state-funded client financial statements on a regular basis to verify their accuracy and develop an internal reporting system to take corrective actions when necessary**.

Recoupment reporting. The department is permitted to recover benefits from the estate of clients in the event of their death or file a property lien when the client has entered a long-term care facility and is not expected to return home. The department cannot measure or report on the results of its efforts to recover state funds expended on behalf of CHCP clients through the recoupment process. Current recoveries are recorded according to program (i.e., AFDC, State Supplement, or Medicaid). DSS does not further refine their reporting of either estate or lien recoveries in such a way as to distinguish how much is being recovered on behalf of the CHCP. In addition, because the department does not account for any funds that are recovered from the client or their estate, it misstates the costs of the program. **Therefore, the program review committee recommends:**

> **the department develop the capacity to report on the results of its recoupment efforts for the state-funded clients and, if possible, the waiver clients. These recouped funds should be included as part of the department's annual CHCP report and incorporated into the methodology used for the estimated savings of the program.**

If the home care program continues to expand, the ability to adequately forecast the costs and demand for services will be crucial. Additionally, in order for the program to maintain its credibility, the department must be diligent in monitoring the program's activities. These critical needs will be heightened if the program becomes part of a larger effort to plan for the long-term care of elders across programs as discussed in the first recommendation.

Quality assurance and performance measures. In an atmosphere of finite resources, it is essential that state programs include a mechanism to ensure a quality product is delivered. This is especially true when the state does not directly administer a program and relies upon the private or nonprofit sector for implementation. Measures must be taken to verify that services

meet at least a minimal standard. Performance and quality assurance measures are usually employed to assist an agency in determining whether programs are making a difference or having the desired impact.

Principles of quality assurance. The principles of quality assurance require that an agency develop specific quantifiable standards for care and service delivery, monitor or review the service received against the specified standards, and assure compliance through enforcement efforts after problems have been identified. Quality in service delivery is often a difficult concept to measure. Three approaches to quality assurance are usually employed to assist in determining what to measure. They are:

- **Structural measures** - refer to standards that reflect the basic characteristics of a provider of care, such as personnel requirements, organizational structure, and administrative procedures. Examples of structural indicators would include caseload per worker per day, staff certification levels, staff knowledge and staff turnover rates;

- **Process measures** - examine what is to be done to and for the patient. These measure are basically task-orientated and focus on current norms of practice. Process indicators would include frequency of supervision, time between service request and the provision of care, and frequency of client contact; and

- **Outcomes measures** - examine the results of care. They consider the measurable change or stabilization of a client. Outcome indicators may include change in ADL or IADL status, infections, weight gain or loss, and client satisfaction.[15] (See Appendix H for a complete description of indicators).

Lack of formal system. The program review committee found no formal quality assurance system to systematically oversee the program. Although both DSS and the Access Agencies perform some quality assurance activities, these activities are limited and are largely aimed at structure and a few process issues. The CHCP has one formal outcome measure. It requires Access Agencies to ensure that 80% of clients remain in the community for 18 months. Currently, the average client remains in the program for 20 months.

The committee also found that each of the quality assurance processes - the development of standards, monitoring, and enforcement - need to be strengthened. DSS, for example, has

[15] General Accounting Office, *Long-Term Care: Status of Quality Assurance and Measurement in Home and Community-Based Services,* GAO/PEMD-94-19, (Washington, D.C., March 1994) and Patricia Riley, *Quality Assurance in Home Care,* #H-6, (Washington, D.C.: Public Policy Institute, AARP, February 1989).

established a uniform assessment tool and reviews individual care plans developed by the Access Agencies. While each individual care plan is checked by a DSS employee, there is:

- no system of guidelines to measure the reasonableness and adequacy of care plans;
- no systemwide aggregation of data to determine if any variation occurs among service regions or mechanism to assure equity; and
- no retrospective examination of the plan by DSS to ensure it remains within the cost caps, or confirm its efficacy.

While precise guidelines may be difficult to develop immediately, there should at least be a "red-flagging" of cases that appear to be well outside of the norm for additional scrutiny.

Quality assurance within Access Agencies. Under their contract, the Access Agencies are required by DSS to have quality assurance committees composed of independent health care professionals who review client records on a quarterly basis. DSS is to receive a report detailing their efforts annually. *The program review committee found the Access Agencies have not received any direction from DSS as to what the composition of the committees should be or how they should operate. Thus, there is no standardization among the three Access Agencies and each agency may determine the structure and emphasis of its committee.* With the addition of two other care management agencies (the Southwestern Connecticut Agency on Aging and the South Central Connecticut Agency on Aging), the program review committee has concerns about the consistency of reporting and the diminished ability to compare performance among the three providers of care management without some guidelines.

DSS reporting of quality assurance activities. The program review committee found DSS compiles few reports and conducts limited analysis of its own or the Access Agencies' quality assurance activities. The department has issued six reports since 1989 on various aspects of its quality assurance efforts. Only three reports involve the CHCP; while the other four reports concerned the Preadmission Screening and Community-Based Services program (PAS/CBS), the predecessor program. The reports published by DSS are not issued on a regular basis and the last report, a client satisfaction survey, was issued in July 1994. (The Access Agencies are also required to conduct client surveys on a regular basis.)

Although the program review committee recognizes client satisfaction surveys are an important part of a quality assurance system, they are limited and should not be the only focus of a quality assurance effort. The CHCP population is very vulnerable and service dependent. Frail elders, therefore, may be reluctant to provide negative feedback. Consumer input is useful but other measures need to be taken into account to validate what is occurring in the field.

Reporting under DIM. Prior to the CHCP, the former Department of Income Maintenance (DIM) conducted a compliance review of the two care management agencies

administering the PAS/CBS program in 1990. The review team, composed of DIM staff, issued a number of findings and recommendations to assist in improving the PAS/CBS program. The report focused on structural and process measures and is instructive as to the types of problems that may arise when multiple care management agencies are involved with client care. Some of the problems noted include:

- Inadequate documentation of deficiencies in clients' plans of care and specific times of day and days of the week for client care were not consistently documented;

- Service dates on plans of care differed from those on service orders and first contact with clients, which is supposed to occur within 24 hours of referral, were not always documented; and

- Delay notices were not sent to DIM when client assessments were not completed in the required seven days, and plan of care reviews were not completed on time and were incomplete.

DIM did not issue a follow-up report and a similar statewide effort for CHCP has not been undertaken. Regular compliance reviews should be a part of quality assurance efforts to at least ensure the practices followed within the agencies implementing the program comport with the policy and procedures promulgated by DSS. **Therefore, the program review committee recommends:**

DSS shall develop a formal quality assurance and improvement plan. This plan should define quality, identify indicators of quality, and establish a regular review of the program and feedback mechanism. At a minimum, random case audits should be conducted on a regular basis by the department and reports developed detailing the results of those audits. Further, cases well outside the expected norms in terms of costs or service utilization should be red-flagged for additional review.

The department shall strengthen its current efforts by developing additional structure and process measures and regularly monitor and report on those measures to ensure compliance. In addition, the department shall develop guidelines for treatment effectiveness based on the assessment of the need for different types of community-based services, cost-effectiveness of those services, and the impact on patient health status. The guidelines should be used to develop outcome measures and define the parameters of the quality assurance system.

The management controls outlined above are intricately interwoven and dependent on each other. Planning and monitoring efforts require a good MIS system. MIS reports provide the necessary feedback for a quality assurance system. Taken together, the MIS system, planning, monitoring, and quality assurance activities, serve to gauge how well a program is being implemented and provide the basis to draw comparisons between the Access Agencies, DSS field and central offices, and among clients. It is insufficient just to monitor individual care plans and accumulate demographic information about the program. Performance measures should be developed and data need to be aggregated in a meaningful way. Without sufficient and timely information about program operations, the department may not know the best use of state resources. It is management's responsibility to establish and maintain an appropriate management control structure. With an improved evaluation capacity, the state may develop objective information about program performance and quality.

Awareness of the CHCP

Program referrals. *The department does not compile information on how elders are referred to the CHCP.* The committee believes knowledge about the referral source, whether it be a relative, neighbor, health care professional, or the individual seeking services, is valuable program information that could be used to conduct better outreach and targeting of elders.

Outreach. In addition, other health care professionals (such as geriatric physicians, hospital discharge staff, and home health care workers) often deal on a day-to-day basis with frail elderly who could benefit from CHCP services, but are at immediate risk of nursing home placement. These health professionals often are involved or assist in the decisions made about settings or sources of care. *The program review committee found no formal strategy to keep potential referral sources informed of the program.* According to the survey of hospital discharge staff, only 38 percent were aware that admission into CHCP had reopened.

The committee recognizes that DSS has been in the difficult position of whether to conduct outreach when there are already a significant number of individuals on the waiting list for both the waiver and state-funded program. Public awareness activities may seem like a debatable exercise while funding is limited and waiting lists exist for services. However, key members of the aging network should be kept informed and educated as to what the program does, the types of services offered, and current intake status. **The committee recommends:**

> **the Department of Social Services compile statistics on the referral sources for each potential applicant to the program. The Department of Social Services should identify key providers in the aging network who refer clients to the CHCP and determine the level of knowledge about the program. The department should develop community training programs and a procedure to keep hospitals and geriatric providers informed about the CHCP program on a regular basis.**

Distribution of New Openings for the Medicaid Waiver Program

Allocation of openings. The department reopened admission on a limited basis to the waiver program in August 1996, and determined 2,590 elders could be offered services on a phased-in basis in FY 97. The number of openings per month were limited and disproportionately allotted among regions. Table VIII-1 shows the number of slots allocated to each region. For August, September, and October a total of 298 slots per month were available and dropped to 212 for the remainder of the fiscal year. The region allocated the greatest number of slots was North Central, followed by South Central, and South West. The Eastern region was allotted the smallest number.

Table VIII-1. Distribution of Openings Per Month Per Region: FY 97.

Region	*Percent*	*Cases per Month: Aug., Sept., Oct.*	*Cases per Month Nov. - June*
Eastern	15.4%	46	33
North Central	24.2%	72	51
North West	18.6%	55	40
South Central	21.9%	65	46
South West	20.0%	60	42
Total	100%	298	212

Source: DSS, Alternate Care Unit.

Allocation formula. The methodology used to allocate the number of openings per region was based on the formula to distribute Older Americans Act Funding among the Area Agencies on Aging. However, the department modified the formula to conform to its own regional boundaries (shown in Figure VIII-2) which differ from those of the Area Agencies on Aging. The formula adjusts for differences in the population using social and demographic characteristics related to the need for assistance in later life in order to more fairly distribute Older Americans Act funds. The factors used are identified in the Older Americans Act as defining the target population for community service programs under Title III of the Act. These are:

- all persons age 60 years or older;
- persons age 60 years or older who are members of racial or ethnic minorities;
- persons age 60 years or older with incomes at or below the poverty threshold;
- persons age 60 years or older unable to perform basic activities without assistance;

- persons age 60 years or older living in rural communities; and
- persons age 60 years or older who are both members of racial or ethnic minorities; and have incomes below the poverty threshold.

The underlying assumption is that persons with these characteristics are not distributed in the same pattern as the general population. By weighting the general population to reflect these populations in need, funding will be more equitably distributed than if distributed by the general population alone. In addition, half of the funding is divided into five equal portions, and the other half by the population factors, because a minimum level of funding is believed essential to maintain a viable service program in any region.[16]

The program review committee endorses the use of this formula by DSS in an effort to ensure better targeting of eligible elders and more equitable distribution of program openings among regions. However, the formula used should be refined further to be consistent with program eligibility criteria and reflect elders aged 65 or older rather than aged 60 or older. **Therefore, the committee recommends:**

> **the department continue to use the factors contained in the Older Americans Act formula for allocation of program openings on a regional basis but the factors for the target population should be modified to include only those persons aged 65 or more.**

Before program admission was closed in FY 96, all elders who qualified for services were served on a first come first served basis. Given the fact funding is now limited, the program is unable to provide services to all who meet the eligibility criteria. It is appropriate therefore that the state allocate openings based on characteristics that help identify elders eligible for services. Use of a formula to accomplish this will allow DSS to better target and serve the state's frail elders. In addition, when the state-funded program is reopened, the department should continue using this methodology.

[16]Department of Social Services, Exhibit II, Revision to the Intrastate Funding Formula in the Connecticut State Plan on Aging for October 1, 1991 to September 30, 1995.

Figure VIII-2. DSS' Regional Boundaries.

APPENDIX A
DEPARTMENT OF SOCIAL SERVICES' RESPONSE

DEPARTMENT OF SOCIAL SERVICES FORMAL COMMENT ON THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE FINAL REPORT ON SERVICES TO THE ELDERLY TO SUPPORT DAILY LIVING.

Issue #1:

Renewal of the Medicaid waiver application

Program review committee staff found DSS made two significant substantive changes to the elder home care (CHCP) Medicaid waiver without first reporting and obtaining legislative input as required by law; ***and*** *committee staff found neither the renewal application, nor subsequent amendment that decreased the number of clients to be served, were submitted to the legislative committees, as required by statute;* ***and*** *program committee staff also found the department was in violation of Connecticut General Statutes 17b-8(a) when it submitted its waiver without legislative oversight.*

As adopted, these findings were based on the following research of the committee staff. First, the department imposed a 5 percent cost cap in the CHC program under the submitted waiver renewal application in March 1996, over a month prior to the legislature's adoption of the 1995-97 Connecticut State Budget; second, the department is required to submit all federal waivers of any assistance program to the Appropriations and Human Services Committees pursuant to C.G.S. 17b-8(a); third, committee staff found no 5 percent expenditure cap in the CHC in the 1995 Appropriations Act (Special Act 95-12); finally, committee staff found no 5 percent expenditure cap on the CHC in the Governor's 1995-97 Recommended Budget.

From these findings the committee staff concludes that the department violated the law and the intent of the Connecticut General Assembly. The department would conclude the same were these findings accurate. However, these findings are insufficient for the following reasons.

First, C.G.S. 17b-8 does not require the department to submit any federal waiver renewal or amendment to the Appropriations and Human Services Committees. The statute speaks only to applications for federal waivers and is silent to amendment and renewals of such federal waivers. No distinction is made under the statute between initial applications and subsequent applications. Routine operational issues are exempt from the provisions of the statute. Moreover, there is no legislative guidance in the statute that an amendment or renewal of a federal waiver constitutes an application. Nor has any court provided interpretation of these provisions. Notwithstanding this, the department has favored submittal of amendments that constitute substantial programmatic revisions to a federal waiver program to the Connecticut General Assembly in accordance with 17b-8.

At issue is the need to interpret what modifications constitute a program modification that

goes beyond a routine operational issue. Again, there is no statutory or other legal guidance in this regard. Nor is there guidance in distinguishing between budgetary issues and programmatic issues in the statute. In this regard the department has reasonably interpreted 17b-8 to govern in situations pertaining to programmatic modifications to a federal waiver program. To interpret this provision otherwise would require the department to submit federal waiver renewals and amendments upon any fluctuation in amounts appropriated by the Connecticut General Assembly for such purposes because these appropriations would invariably modify the number of eligible persons served in any federal waiver program. Moreover, there is no evidence that the Connecticut General Assembly intended submittal under these circumstances.

Indeed, the Legislature's oversight of such matters pursuant to C.G.S. 17b-8 has traditionally focused on the programmatic features of federal waiver programs while the budgetary provisions of federal waiver programs are subject to the legislative enactment of appropriations in support of the federal waiver program. The department has not made any revisions concerning caseload and budget projections to any federal waiver program that was not supported by appropriations approved by the Connecticut General Assembly. The changes contained in the 1995 renewal of the CHC waiver program contained no revisions to the programmatic features of the program. Modifications to the number of individuals served in the CHC program have been, and remain, governed by legislatively adopted appropriations.

The committee staff recognizes in their findings the lack of guidance in the statute. They offer no reasoned interpretation of the statute. Instead, it is summarily stated that the department violated the statute. Their own recommendation for modifying the statute to clarify that waiver renewals and amendments are subject to submittal is tacit admission by the staff of the deficiency in the legislative guidance in the statute and supportive of the department's need to interpret the statute.

Second, the 1995-97 Connecticut State Budget as adopted by the Connecticut General Assembly under Special Act 95-12 imposed a 5 percent expenditure cap in the CHC program. Please see the attached provision found on page 532 of the 1995-97 Connecticut State Budget published by the Legislature's Office of Fiscal Analysis. The 5 percent expenditure cap identified in the legislatively approved budget reflects appropriated amounts for the CHC program in the Legislature's adoption of Special Act 95-12. Additionally, please find attached the provision from the 1995 Appropriations Committee adopted budget as further indication of the legislature's intent that a 5 percent expenditure cap be imposed in the program.

Third, the Governor's 1995-97 Budget Recommendation includes a 5 percent expenditure cap in the CHC program. Again, please see the attached page of the adopted Connecticut State Budget in support of this conclusion. Finally, the department in no way imposed the 5 percent expenditure cap in the CHC program prior to the legislative adoption of the cap. The department was required to submit the renewal of the CHC waiver in March 1995 to the

Health Care Financing Administration (HCFA) of the federal Department of Health and Human Services. A budget projection reflecting revisions to the number of clients that could be served under the pending 5 percent cap was included in the submittal. It was communicated to HCFA that these Projections were contingent on the final adoption of appropriations by the Connecticut General Assembly. The imposition of the 5 percent cap in no way precipitated legislative action. Should the legislature have not adopted the budget cap, the department would have submitted a revised budget projection to the renewal submittal and no cap imposed in the program. As approved by the Connecticut General Assembly, the budget cap was imposed in July 1995 following the effective date of the 1995-97 Connecticut State Budget.

Based on the above analysis, the report should: (1) acknowledge that the Department of Social Services reasonably interpreted C.G.S. 17b-8 given the recognized lack of guidance in the statute and acknowledge there was no attempt by the department to circumvent the statute and the intent of the Connecticut General Assembly; (2) acknowledge that the committee staff findings and recommendations regarding the legislatively adopted 5 percent expenditure cap in the CHC program are in error and that the Department implemented this budgetary provision in accordance with the intent of the Connecticut General Assembly; and (3) acknowledge that the department included the 5 percent expenditure cap in its March 1995 waiver application as a prudent budget projection with commensurate caseload projection adjustments and that the department indicated to HCFA that the budget and caseload projections were contingent on the approval of appropriations by the Connecticut General Assembly and that the department in no way implemented the 5 percent expenditure cap in the program prior to the approval of legislative appropriations.

Committee Response:

The Legislative Program and Review and Investigations Committee stand by its findings and recommendations on pages 99 - 102.

Issue #2:

Long Term Care Policy Development

While the department agrees that long term care planning is important, the recommendation for a long term care planning committee seems to be too little, too late. As noted in the report, the department has been directed to work on a much broader initiative which integrates primary, acute and long term care through both Medicare and Medicaid funding under an 1115 federal research and demonstration waiver. The department currently reports to the Legislative 1115 Waiver Development Council on this initiative. The council is monitoring the integrated approach of this initiative. Moreover, the department is

coordinating a comprehensive planning process in this initiative and believes this process is the appropriate vehicle for the long range planning that is needed.

Based on the above analysis, the department is not in support of establishing a long term planning committee.

Committee Response:

The Legislative Program Review and Investigations Committee stand by its findings and recommendations on pages 95 - 99.

Issue # 3:

Management Information Systems

The department recognized the need for improved data several years ago and finally was able to develop a system and begin receiving data from CCCI last June. The department is in the process of refining the system and beginning to analyze data for purposes of program and fiscal monitoring. The department acknowledges the need to improve the system and is in process of making such improvements.

The department's first priority is to network between its central office and the field offices rather than networking directly with the access agencies. Through its current contract, the department receives data transferred from the access agencies every six months and is considering increasing that schedule in the contract renewal.

Networking with access agencies and changing the specifications for their data systems would have high cost and would be a change from the expectations on which they bid for the contracts. The department needs to review whether this is a necessary step to achieve program management needs.

Inconsistencies between access agencies and DSS data are due to the newness of the department's data system and the timing of when data is received, reported, and updated.

Data was provided to program review staff within a week after it had been received by DSS; DSS staff had acknowledged that they had not time to analyze the data or do any data verification before Program Review began its study.

The department recommends that the committee support the department's efforts to develop improved data systems for the CHC program.

Issue #4:

Waiting List

Department staff who participated in field staff interviews indicated that the committee staff were not simply asking staff to explain the meanings of the variables on the waiting list but to draw conclusions about why the numbers were distributed as they were. Many staff who were asked these questions were not in a position to answer such questions, and this seemed to have caused some of the confusion. Another factor which created some confusion initially was the loss of the three key staff involved in tracking the waiting list within a few months. The department feels that it has subsequently provided ample explanations about the waiting list.

The committee staff had indicated that the department's procedure manual did not contain procedures related to the waiting list. This is inaccurate. The manual contains extensive information about the waiting list. The one item which had not been included in the manual was the coding sheet related to tracking status on the waiting list; however, this was provided to the staff in January 1996.

The department acknowledges minor data inaccuracies which are due to human error; these are corrected when identified.

The committee staff raised questions about the department's efforts to enroll individuals onto the program after intake was reopened, but the staff failed to provide complete explanations which had been provided by the department. On the day prior to the hearing, the department had FAXED committee staff an analysis of waiver intake which demonstrated that as of November 1996 the Department had enrolled an estimated 536 individuals and had 673 individuals in process (including 250 individuals who were actually receiving services but were awaiting paperwork before they would be officially counted as enrolled on the waiver. For most individuals, the greatest delay in the processing of their Title XIX application which requires extensive verification of income and assets.

Regarding the distribution of openings on the Medicaid waiver program, the committee accepts the recommendation to recalculate the formula to base the distribution on the population aged sixty-five and older. The department will do this recalculation to determine whether the adjustment makes any difference in the distribution by region, and if so will make adjustments for future intake.

The department is in agreement with the findings and recommendations to modify the formula for distributing openings in the CHC program to reflect the percent of the population 65 and older rather than 60 and older.

Issue #5:

Program Planning and Fiscal Monitoring

The state-funded program had been closed for two years. In order to assure that the program could reopen with no limitations on intake, the Governor recommended that the budget be nearly doubled, and the Legislature approved the recommended increase.

Had the appropriation been more limited, the department would have been required to control intake during the year in order to assure that it could live within the budget. This was clearly not the intent of the Governor or the Legislature at that time. The higher budget assured that the program would have an open door throughout the fiscal year.

The department did project a surplus at the end of FY '95 even though intake was open. This was because it took a while for referrals and admissions to reach the point where they had been prior to the closure of the program, consequently many individuals were served for only part of the year, thus incurring lower costs for that fiscal year. The department requested permission to carry-over funds into FY '96 in order to continue services to those clients throughout the full fiscal year and to continue admitting new clients.

The department was well aware that the money needed for FY 96 needed to be greater than FY 95. Unfortunately, the budget for '96 was reduced instead of increased in the legislative appropriations. This created the need for a waiting list in FY '96.

Since the state-funded portion of the program has always been limited by appropriation, it has never, except in FY '95, been possible for the department to meet demand. Consequently, the department has not needed to project the possible demand for the program.

The department is in agreement with the committee staff recommendation directing the department to project the possible demand for CHC the program.

Issue #6:

State-funded client's financial statements

While the department does not directly verify client income for the state-funded program, The department has required its contractor to confirm a client's income and assets at the time of the assessment or reassessment.

The department also periodically runs bank checks for general verification of client reported information, and state-funded clients have been periodically included in those checks. The department supports the recommendation to randomly verify state-funded client financial statements on a regular basis.

The department is in agreement with randomly verifying state funded clients' financial statements on a regular basis.

Issue # 7:

Recoupment reporting

The department will explore the feasibility of reporting the results of recoupment for state-funded and waiver clients. It should be noted that these clients may have another primary eligibility status through which the Department would be reporting these recoupments, therefore, the Department will want to assure that separate reporting for the CHC program does not result in double counting of recoupments.

The department questions the appropriateness of incorporating the recoupments into the estimated savings for the program since the recoupments may be related to services delivered in different years from the report year.

The department recommends exploring the feasibility of reporting the results of recoupment for CHC program clients.

Issue #8:

Internal Quality Assurance System

The department provided the committee staff with its framework for quality assurance which had been developed in 1988. (This document bears the name of the predecessor program, but it is still the department's guiding document). This document identifies the various areas of quality assurance discussed by the committee staff: structure, process, and outcomes, and identified how the Department monitors each element.

Due to the elimination of licensing for CAM agencies, some of the structure and process, measures which had been handled by the licensing process were no longer required. The department recognized the need to enhance its quality assurance activities to compensate for this (without recreating the licensing process) and had increased the frequency of its internal Quality Improvement Committee in order to review and enhance the framework of monitoring the new access agencies. (The committee staff were advised of this on 10/3/95).

The department questions the recommendations for a definition of "quality" and for "guidelines for treatment effectiveness." Both of these are very much related to individual situations, preferences and needs, and to date no national research has been identified which gives effective guidance in these areas. The department certainly intends to continue to work toward these goals, but recognizes that establishing guidelines prematurely can lead to changes in treatment patterns which may not be in the best interests of clients.

As recommended by the committee, the department will continue to conduct random case audits. The department agrees with the suggestion to also selectively sample cases which are outside of "norms." The data base discussed above will enable the Department to identify such norms and cases which exceed the norms.

It should also be noted that in 1995 the department conducted a financial audit of the program and has recently begun another audit. Moreover, the State Auditors conducted separate audits on the program in 1995 and 1996.

It should be noted that the period which the committee staff focused on for lack of quality assurance activities was the two-year period during which the major restructuring of the CHC program was taking place. Staff who would normally be involved in case record reviews and other quality assurance activities were heavily involved in developing program policies and procedures to implement waiting list and the change to new access agencies.

The department recommends that random case audits be regularly scheduled including a selective sample of cases outside the norm.

Issue #9

Quality Assurance within Access Agencies

As noted above, removal of licensure for CAM agencies eliminated a level of oversight for care management activities. The department understood this to be the intent of the legislature and did not feel that it should attempt to recreate the licensing process for access agencies.

The department, through its regulations, did require that the access agencies develop quality assurance committees but intentionally left the flexibility to the Agencies to determine the appropriate composition for the committees. The department received extensive input on these regulations from its Home Care Advisory Committee including representatives from the home health associations, adult day centers, area agencies on aging, municipal agents, and other advocates.

The department provided a report of a program compliance review conducted by the federal Health Care Financing Administration (HCFA) in December 1994. This report found that: "Overall, administration of this waiver was . . . in compliance with the regulations and the approved waiver document." This report had particularly high praise for the quality of the care planning as documented in case records.

Especially worthy of note were the progress notes maintained by the case managers. The notes were clear and concise and clearly documented frequent contact with the client, involvement with the interdisciplinary team (IDT) in developing and reviewing plans of care, and close monitoring of the services provided.

The department provided 7 internal reports to the committee staff related to programmatic quality assurance activities. The department also advised staff of additional activities which had been conducted but which, due to lack of staff resources, had not been documented in writing. These additional activities included:

*Case record reviews of clients in Waterbury and Wethersfield in May, 1994.

*Mail and telephone survey of clients (Spring 1996) who were not receiving care management services to determine their satisfaction with services, whether they knew who to call when help was needed, and how they were managing.

*Record reviews of the two new access agencies conducted in October 1996.

Much of the department's QA activities in the past had been in the area of structure and process. It is for this reason that in recent years the department has emphasized client satisfaction as its first measure of client outcomes.

The department has also been planning to use its new data system as a key tool in identifying outcome measures. In its recent RFP, the department had identified a new variable on the assessment tool which was specifically designed to be related to client outcomes (variable: care manager's assessment about the likely outcome in the coming year, i.e., improvement, stabilization or decline.) It is the department's intent to examine whether actual changes in client status are related conditions which were predicted or to conditions which were unanticipated. This work is in its infancy, but the department had made it clear to committee staff that this work was in process and would become part of the formal quality assurance plan.

The department recommends enhancements to the department's quality assurance system for access agencies.

Issue #10:

Awareness of CHP Program

The department has an extensive mailing list for the CHC program which includes hospital discharge planners and social workers, municipal agents, adult day centers, senior centers, the home health and nursing facility associations, associations, and other interested parties. The department regularly sends out program information to these groups.

In July, the department provided training to municipal agents and advised them of the anticipated opening of the CHC program.

In August the department held its Home Care Advisory Committee meeting and advised all members of the reopening of the program. As noted above, this committee includes all key associations and had representation of hospital discharge planners and social workers until members recently resigned.

In September and October, the department conducted 6 training sessions for hospital discharge planners and social workers and nursing facility staff. These sessions included updates on the CHC program and reinforced the reopening of the program. It is not clear when the committee staff surveyed the hospital discharge planners, but it is the department's position that reasonable efforts were made to inform all parties involved about the reopening of the program even though the department already had more than enough referrals to fill all available slots.

The department's new data system does include information about the source of the referral. This information is not automated for current clients but is currently entered on individuals as they enter the program.

The department recommends enhancements to the department's public awareness initiatives for the CHC program.

Issue # 11

Administrative costs of the CHC program

The committee has discussed the ratio of administrative expenses to costs for direct services and was given a misleading impression that 20 percent of program costs are spent on administration. The department would like to clarify that the total cost of the direct services is 96 percent of the program budget. Care Management services are clinical services of a nurse or social worker who develops the care plan and monitors the ongoing needs of the individual. This is not an administrative cost although that is a common misunderstanding. To determine the total percentage of direct services, one must add the care management cost (14.4%) and the cost of other direct services (81.5%).

No action is need. This is for informational purposes of clarification only.

APPENDIX B
HISTORY OF HOME CARE IN CONNECTICUT

History of Home Care in Connecticut

The State of Connecticut has funded nonmedical home care services for the state's frail elderly since the mid-1950s. The state allocated funds through the Department of Public Welfare for services like homemaking, chores, adult day care, home delivered meals, and companionship. The state's commitment to home care has grown over the years. This is evidenced by several initiatives, described below, which culminated into the current program.

Essential Services. The Essential Services program has been in existence since the 1960s under various names and operated by various state agencies. The program funded homemaker, companion, chore, and other services to enable low-income persons with significant impairments to remain at home. The target population included the elderly, disabled adults, and AFDC eligible families. A caseworker was responsible for determining the needs of the client by examining the individual's physical environment and consulting with the client's physician. In addition, the caseworker was responsible for arranging services, ensuring that services were delivered, and monitoring the client's progress.

On July 1, 1981, responsibility for the operation of the program was transferred from the Department of Income Maintenance (DIM) to the Department of Human Resources (DHR). Admission to the program for the elderly ended in 1990, as noted below. In its final year, the Essential Services program served an average of 2,281 elderly per month.

Triage. The Triage program began as a research and demonstration project to provide an alternative health care delivery system to elders aged 65 and older, or disabled elders 60 or older and already eligible for Medicare. The purpose of the program was to examine the needs of each eligible client and ensure services were provided to meet those needs. Triage essentially performed a coordination, assessment, and monitoring function for its clients. There were no income eligibility requirements, though some clients paid for the cost of their care.

The project started in 1974 and during its developmental period, a homemaker-home health care agency, Community Health Services of Central Connecticut, administered the program. In 1975, Triage Inc., a private nonprofit agency, was incorporated and took over the management and control of the program. Triage operated in a seven town region and served an average of 1,400 clients annually until funding was terminated in 1981.

Strengthened Assistance for Independent Living (SAIL). Another major program to promote home care for the elderly began in August 1976 as a demonstration project to create alternatives to institutionalization. The program, called SAIL, was administered by the State Department on Aging (SDA) and implemented by the five Area Agencies on Aging (AAAs) within their respective geographical regions. SAIL was not available statewide because of insufficient funding. At its peak in 1980, SAIL served 1,900 clients and covered 83 towns.

The eligibility requirements for SAIL required that a person must: be aged 60 or older; reside

in a town were services were available; and be within 90 days of inappropriate institutionalization or be inappropriately institutionalized. A variety of services were offered including both home health and community-based services. There were no financial eligibility limitations on receiving coordination, assessment, and monitoring services, however, priority for these services was given to those who had greater financial need.

Promotion of Independent Living for the Elderly (PIL). On July 1, 1980, the SAIL program was renamed Promotion of Independent Living for the Elderly and Connecticut Community Care, Inc. (CCCI) was established to administer it. The State Department on Aging (SDA) determined a single statewide administrative structure was needed to foster more uniformity among the five regional programs. The eligibility criteria for the clients and the provisions for payment of services remained the same. The SDA operated this program primarily with state funds, although federal resources were also available through what has become the Social Services Block Grant Program.

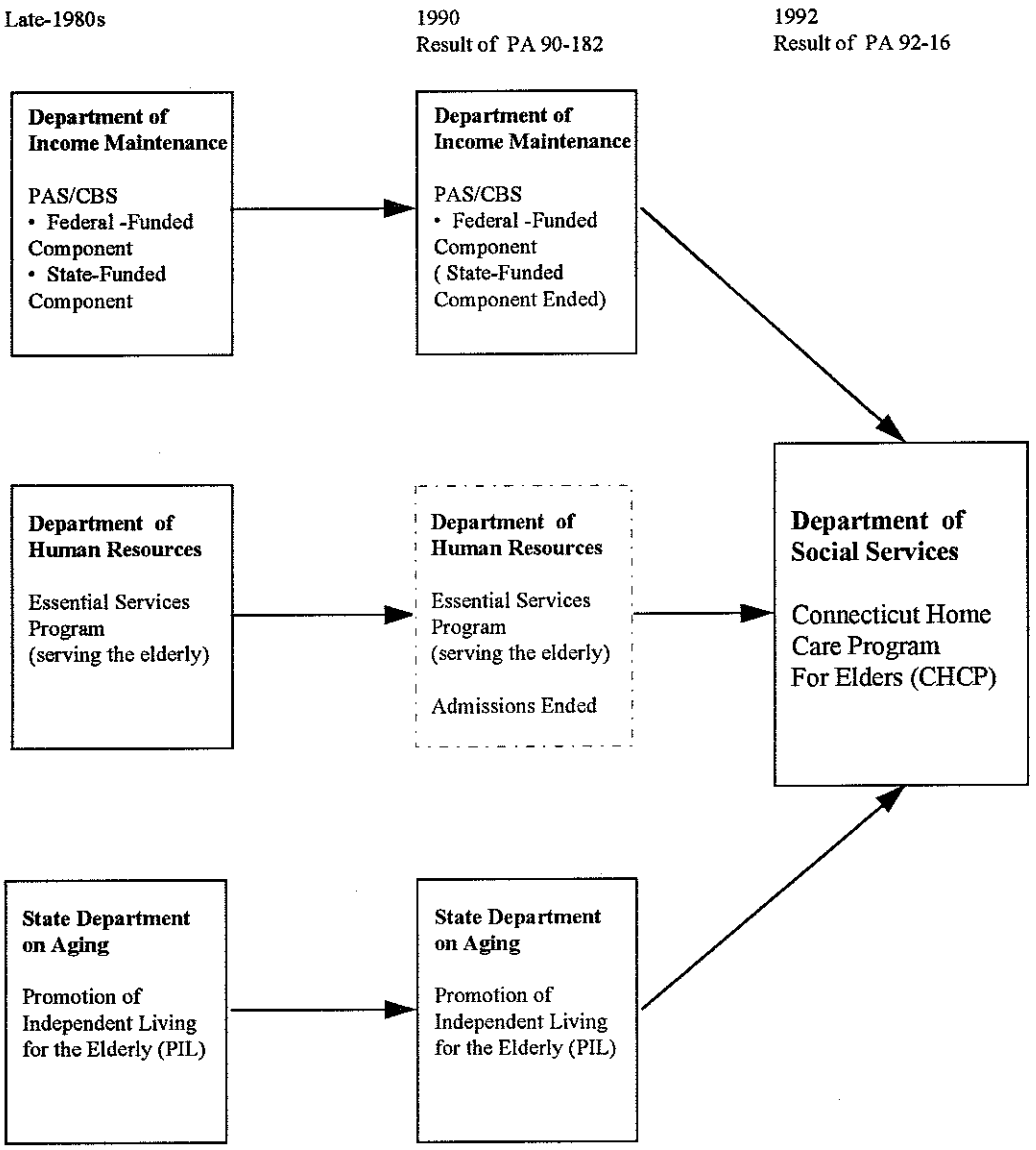
Long Term Care Preadmission Screening and Community-Based Services Program (PAS/CBS). In 1985, Public Act 85-556 called for the Department of Income Maintenance (DIM) to apply for a Medicaid waiver to maximize dollars and serve more clients. In addition, the act established a state-funded program component for individuals ineligible under the provisions of the waiver. The waiver program, called the Long Term Care Preadmission Screening and Community-Based Services Program, began statewide operation in 1987. It was targeted to very frail elders identified by hospital or nursing home staff as likely to be admitted to a nursing facility within 60 days.

Recent developments. By the late-1980s, the evolution of home care in Connecticut resulted in three separate programs operated by three different state departments, as shown in Figure B-1. In 1990, the General Assembly moved to consolidate home care services for elders into two programs. Public Act 90-182 ended admissions for elders in the Essential Services program operated by Department of Human Resources and in the state-funded portion of the PAS/CBS program. New applicants in need of state-funded home care services were referred to the PIL program at the SDA.

Connecticut Home Care Program for Elders (CHCP). The second phase of the consolidation came at the end of the 1992 session. The Connecticut Home Care Program for Elders began in July 1, 1992, as a result of a merger of the three major programs:

- Long Term Care Preadmission Screening and Community Based Services Program operated by the former DIM;
- Promotion of Independent Living program operated by the former SDA; and
- elder services portion of the Essential Services Program operated by the former DHR.

Figure B-1: Consolidation of Connecticut's Home Care Programs



The CHCP is housed within the Department of Social Services' Alternate Care Unit. The program has two components; one that is state-funded and the other operates under a Medicaid waiver which provides matching federal funds.

The goals of CHCP are similar to the previous home-care programs. The objective of CHCP is to assess whether an elder can be appropriately served in the home in a cost-effective manner. This is achieved by providing a range of home care services to eligible individuals.

Summary

Although Connecticut has provided home and community-based services to the elderly for several decades, not everyone who is eligible for services has been able to receive them. Either funding, the geographical area, or other eligibility requirements have limited the availability of services. With the creation of the CHCP, the state has reduced the fragmentation that had existed in the delivery of home and community-based services. Even though the CHCP's eligibility requirements reduce the pool of potential clients to Connecticut's neediest elderly, funding has not kept pace with the demand for services. Nonetheless, the home care option serves thousands of elderly each year and remains a vital part of the long-term care system.

APPENDIX C
DISCHARGE PLANNING SURVEY

Discharge Planning Survey

The program review committee sent out 32 surveys to discharge planners throughout the state. Of the 32, 23 (or 71.9 percent) were returned. Responses to the questions are provided below. (Percentages may not add to 100 due to rounding).

1.	Do you know about the Connecticut Home Care Program (CHCP) that is administered by the Department of Social Services Alternative Care Division ? (IF NO, please return this survey without completing it). **(N=23)**	**Yes 22 (95.7%)** **No 1 (4.3%)**
2.	Do you know the thirteen specific home and community-based services available under the CHCP?**(N=22)**	**Yes 11 (50.0%)** **No 11 (50.0%)**
3.	Do you know the financial criteria that applicants must meet to qualify for the CHCP?**(N=22)**	**Yes 19 (86.4%)** **No 3 (13.6%)**
4.	Do you know the functional criteria applied by the Department of Social Services to screen applicants for eligibility in the CHCP?**(N=22)**	**Yes 15 (68.2%)** **No 7 (31.8%)**
5.	Has the Department of Social Services notified you that admission to the program was reopened in August 1996 (although applicants on the program's waiting list will be offered slots first)?**(N=21)**	**Yes 8 (38.1%)** **No 13 (61.9%)**
6.	Have you ever made referrals to the CHCP program? If no, why not (please check any or all that apply)?**(N=21)**	**Yes 13 (61.9%)** **No 8 (38.1%)**

6 waiting list was in place and patient needed services immediately
1 patient needed higher level of care
2 patient did not meet financial criteria
2 patient did not meet functional criteria
4 too time consuming or difficult to refer
6 other (please explain)

_____

7.	If you have made referrals to the CHCP, approximately how many patients have you referred in the last 3 years? **(N= 10)**	**Total = 240** **Range = 3 to 100** **Avg. = 24**

8. Please rate your overall satisfaction with the interaction you may have had with the Connecticut Home Care Program employees and the Access Agencies who are responsible for continuing care management for CHCP clients. (Please circle only one).**(N=21)**

(Low) 1 **1 (4.7%)**
2 **6 (28.6%)**
3 **6 (28.6%)**
4 **5 (23.8%)**
(High) 5 **2 (9.5%)**
N/A **1 (4.7%)**

9. Please rate the clarity of the information you have received about the program. (Please circle only one).**(N=22)**

(Not 1 **4 (18.1%)**
Clear) 2 **7 (31.8%)**
3 **5 (22.7%)**
(Very 4 **5 (22.7%)**
Clear) 5 **0 (0.0%)**
N/A **1 (4.5%)**

10. How do you feel about the options available to you when discharging a frail elderly patient from the hospital? **(N=22)**

(Not 1 **11 (50.0%)**
Enough) 2 **9 (40.9%)**
3 **1 (4.5%)**
(Sufficient 4 **1 (4.5%)**
Options) 5 **0 (0%)**
N/A **0 (0%)**

11. In your opinion, what type of services are needed (please check all that apply)

14 home care
10 CHCP
15 supportive housing
10 nursing home beds
13 other _____
0 no more are needed

12. Do you currently refer frail elderly patients (65+) to nursing homes who could more appropriately be served by the CHCP program? **(N=22)**

Yes 12 (54.6%)
No 10 (45.4%)

13. If you answered yes to question # 12, how many patients would you have referred to the CHCP in the last month? **(N=10)**

Total = 91
Range = 2 to 30
Avg. = 9.1

14. How many elders (65+) do you work with each month on average that require post-hospitalization long-term care? **(N=22)**

Total = 1,679
Range = 3 to 400
Avg. = 76.3

15. How important is the availability of community-based services (companion, adult day care, housekeeper, etc.) in maintaining people at home and preventing or postponing their institutionalization?**(N=22)**

(Not 1 **0 (0.0%)**
Important) 2 **0 (0.0%)**
3 **1 (4.5%)**
(Very 4 **3 (13.6%)**
Important) 5 **18 (81.8%)**

16. Are there any specific problems with the Connecticut Home Care Program that need to be corrected? (Use additional sheets as necessary). **N=20**

_____

_____

17. Please include any additional comments you may have about the CHCP or home care for elders in Connecticut that would assist in our evaluation. (Use additional sheets as necessary). **N=14**

_____

_____

18. What is your title? **(N=21)**

Assistant Director Social Work	1
Case/Care Manager	5
Continuing Care Coordinator	6
Director Care/Case Management	4
Discharge Planner/Planning Coord.	2
Hospital Social Worker	1
LCSW	1
Manager	1

APPENDIX D
THE CONNECTICUT PARTNERSHIP FOR LONG-TERM CARE

The Connecticut Partnership For Long-term Care

Development of the Partnership. The State of Connecticut initiated a public/private partnership in 1991 to address the growing costs associated with long-term care. There was a recognition in state government that neither the private nor the public sector could by itself pay for the long-term care needs of the elderly and people with disabilities. A collaborative effort developed, named the Connecticut Partnership for Long-Term Care, between insurers, consumers, long-term care providers, and state and federal officials which was the first of its kind in the nation. By offering long-term care insurance with distinctive provisions, the partnership addresses the problem of increasing long-term health care expenses and the consequent burden on the state budget. The Office of Policy and Management (OPM) coordinates the partnership in conjunction with the Department of Insurance (DOI),the Department of Social Services (DSS), the Department of Public Health (DPH), and the Travelers Center on Aging at the University of Connecticut Health Center.

Objectives and target population. The objectives of the partnership are to slow the growth of Medicaid by providing an additional source of payment for long-term care and provide elderly persons with the ability to retain more independence and control over their assets.

The target population for partnership policies are those individuals who would be able to pay for some of their long-term care needs, but would potentially spend down their assets and eventually become Medicaid recipients. The partnership's policies are not appropriate for those individuals who have limited finances, have no assets, are already ill or disabled, or conversely, who have considerable wealth. In addition, the partnership requires that the policyholder be a Connecticut resident when buying the policy and when he/she applies for Medicaid.

Partnership Components

The partnership has three major components. They are:

- the promotion of private, state precertified insurance coverage for long-term care with asset protection;
- the education of Connecticut residents about the need to plan ahead for long-term-care; and
- provide consumer assistance with the purchase of long-term care insurance policies.

Long-term care insurance. The unique feature of the partnership is the combination of private insurance and Medicaid funds to finance long-term care needs. Incentives are provided in purchasing partnership policies as they offer the ability to protect assets that may normally be depleted in paying for long-term care expenses and still allow the policy holder to qualify for Medicaid. When a long-term care insurance policy is purchased, the individual may keep assets equal to the amount the policy pays out for Medicaid-approved benefits. This means once the policy has

paid benefits equal to the policyholder's assets or up to the policy amount, the individual may apply for Medicaid and keep some or all his/her assets from that point on.

Policies in effect. The partnership approved three policies for sale when the program began in 1991 and now have ten preceritified policies representing nine insurance companies. As of June 30, 1996, 2,781 polices had been sold and 1,871 are still in effect. Of the individuals who dropped policies, 74 percent voluntarily withdrew, 4 percent of the policyholders died, and 22 percent dropped for unknown reasons. The age range of those who have purchased polices is between 21 and 84 years. The majority of purchasers are under the age of 65 with an average age of 60.

State certification. The private marketplace offers long-term care policies that are not related to the Connecticut partnership. The partnership, though, offers long-term care policies that include special provisions that provide added protection to the consumer. The special standards are defined by DOI and include:

- insurance agents who sell policies must receive special training regarding the partnership;
- the policy must offer a wide array of home and community-based services in addition to nursing home care; and
- the policy must include inflation protection, must offer benefits no less than an amount set by DOI, and, if you are in danger of lapsing the policy, the company must offer the policy holder a shorter term policy.

Public education. The partnership engages in an extensive effort to educate the public about long-term care planning. As part of that effort, the program educates consumers as to the need for long-term care, mechanisms for financing such care, and the availability of long-term care insurance, including the partnership policies. DSS, for example, provides trained volunteer consumer counselors for those interested in learning about financing their long-term care options. In 1995 alone they responded to over 5,000 calls for assistance. Follow-up surveys indicate that 56 percent of those counseled either bought, applied for, or decided to purchase a long-term care insurance policy. In addition, staff at DSS and OPM gave 75 presentations, reaching 3,000 people, about long-term care in 1995.

Benefit Utilization and Medicaid Impact

A total of 28 partnership policyholders had submitted claims for benefits under their policy as of August 30, 1996. Of the 28 policyholders, four had their claims denied, and 15 of the 24 policyholders whose claims were approved are still receiving benefits. In addition, 8 policyholders have died and one policyholder has exhausted his benefits. The policyholder who exhausted his benefit also apparently spent down all his assets - a matter which is under investigation by the DOI and DSS.

The partnership has had no impact on current Medicaid expenditures, however future savings are anticipated. Using a simulation model, it is estimated, as a result of the partnership policies, Medicaid will break even in the early years of the project with savings rising to 6.8 percent by the years 2016-2020.

APPENDIX E
EXCERPT OF LETTER FROM DSS' MANAGER OF ALTERNATE CARE UNIT

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

25 SIGOURNEY STREET • HARTFORD, CONNECTICUT 06106-5033

May 15, 1996

Mary Ellen Duffy
Legislative Program Review and Investigations Committee
State Capitol, RM 506
Hartford, CT 06106

Dear Mary Ellen:

In response to your May 6th letter, the following additional information is submitted for your review:

1. a. There are no appropriated amounts for the waiver for SFY 93-95. The program operated with the usual flexibility allowed to Medicaid services up until SFY 96 and was able to provide services to all persons who qualified. The program budget for the waiver was limited for the first time in SFY 96 through a 5% growth cap established in the Appropriations Act (p. 532). This limited the expenditures for the waiver community based services to $28.8 million and limited the home health expenditures for waiver clients to $29.6 million. However, even though we established a waiting list in the first month of SFY 96, our fiscal staff project that we will overspend this budget by approximately $8 million.

APPENDIX F
EXCERPT OF LETTER FROM DSS' DEPUTY COMMISSIONER

Connecticut Department of Social Services
Replacing welfare with work.

JOHN G. ROWLAND
Governor

MICHAEL P. STARKOWSKI
Deputy Commissioner

(860) 424-5053 1-800-842-4524 TDD/TTY FAX (860) 424-5057

TO: Maryellen Duffy, Principal Analyst
Legislative Program Review and Investigations Committee

FROM: Michael Starkowski, Deputy Commissioner
Department of Social Services

DATE: October 22, 1996

RE: Questions Regarding Connecticut Home Care Program

We have reviewed your questions on the waiver portion of the Connecticut Home Care Program and have prepared the following responses. We hope that this clarifies these issues. If you have further questions, do not hesitate to call.

1. *A five percent growth cap was placed on waiver expenditures in FY '96. Could you explain how the cap was developed? According to the Office of Fiscal Analysis' Connecticut State Budget 1995-97 (page 532), the department revised the waiver to limit its growth, and this revision was not submitted to the legislature for review. Yet, according to a letter submitted by Commissioner Thomas to HCFA (enclosed) and other DSS staff, it is asserted that the General Assembly made that decision. Could you explain this discrepancy?*

The 5% cap was established as a cost-containment effort and was based upon estimated SFY '95 expenditures. During that year, the department had been anticipating expenditures under the waiver program of $55,574,674. The 5 percent cap, therefore, limited the department's expenditures to $58,353,408 in SFY '96 and to $61,271,079 in SFY '97.

The Governor's recommended budget originally included the savings associated with the restructuring of the waiver program. This recommendation was approved by the General Assembly through the adoption of the Governor's recommendation in the Appropriations Act.

It should be noted that the 5 percent cap is not in statute. It was included as a budget option and incorporated into the budget as referenced in the OFA budget book. Since that time, it has been viewed as the policy guiding program growth. Other statutory provisions related to the restructuring of the home care program were included in Sections 6 through 14 of PA 95-160.

The department believes there is a discrepancy between the Appropriations budget narrative and the statutory requirements of Section 17b-8. Given such a conflict, the department is guided by the statute. C.G.S. Section 17b-8 specifically exempts "routine operational issues" from the mandate for the department to report on federal waiver applications. When the waiver renewal process involves no substantive changes, the department has understood this to be a routine function. In order to maintain continuity of the elder home care waiver, the department submitted the renewal request to HCFA on March 31, 1995, prior to the passage of the 1995 Appropriations Act.

The language in the 1995 Appropriations budget narrative indicated that the Department should submit any subsequent modifications to the General Assembly. However, again, this did not seem to imply that a routine modification to comply with the legislative mandate had to be approved by the General Assembly before being submitted. The Amendment to the waiver, submitted to reduce the caseload (in an attempt to comply with the 5 percent cap) was sent to the General Assembly on September 22, 1995 (see attached).

APPENDIX G
DSS' EXPLANATION OF BUDGET SURPLUS IN STATE-FUNDED PORTION OF CHCP

Explanation of Budget Surplus in State-funded Portion of
the Connecticut Home Care Program for Elders

The state-funded portion of the Connecticut Home Care Program for Elders had been closed during FY '93 and '94. By the end of FY '94, the state-funded caseload had dropped to 1,568. Clearly, the Legislative intent was to reverse this trend, and the budget was nearly doubled the following year (from $8.2 to $15.7 million), to enable the Department to establish unlimited intake.

Doubling the budget assured that there would be no fiscal need to limit the caseload during the year. However, FY '95 was a transition year. The Department added over 1,000 state-funded clients to the program, an average of over 80 per month. (During the same period, the Department also added 2,000 clients to the Medicaid waiver.) No individuals were turned away during FY '95. However, because the net caseload was increasing throughout the year, many of the individuals taken on during the year did not receive services for a full year during FY '95. $15.7 million was the amount needed to continue services to an additional 1,000 clients throughout a full year; it was more than the amount needed to serve them during the transition year.

Unfortunately, the transition period was not understood at the time, and at the end of FY '95, it was wrongly assumed that because the Department had not spent all of the funds in FY '95, the funds could also be reduced for FY '96. This was exactly the reverse of what was needed. The Department needed the full $15.7 million to serve the expanded caseload throughout a full year and continue open intake. However, instead, the budget was reduced in FY '96, leading the Department to institute a waiting list for the state-funded portion of the program in October 1995.

One more complication was added at the end of this past fiscal year. As the caseload dropped during the second half of FY '96, it became clear that the Department could probably take on additional clients under the state-funded portion of the program or else leave some funds underexpended. However, at the same time the Department was projecting a large deficit in the portion of the program funded by the Medicaid waiver. Rather than add clients at the end of the year when it was not certain whether there would be funds to support them in the next year, it was recommended that excess funds be carried over into FY '97, a change reflected in the Appropriations Act.

APPENDIX H
QUALITY ASSURANCE MEASURES

Quality Assurance Measures

The principles of quality assurance require that an agency develop specific quantifiable standards for care and service delivery, monitor or review the service received against the specified standards, and assure compliance through enforcement efforts after problems have been identified. Table H-1 below provides a framework to begin to develop some indicators to define, assure, and measure quality across various stages of care. DSS needs to ask a series of key questions about the goals of the program and identify possible measures. This effort would be an iterative process subject to continued refinement, especially since data collection and analysis to this point has been limited.

Table H-1. Quality Assurance Measures

Activity	*Key Questions*	*Possible Goals or Measures*
Define quality	What goals and outcomes can be identified? Who should be involved in identifying goals and outcomes? To what extent do theses goals and outcomes apply across disability categories and functional needs?	Maintain functional capacity Optimize autonomy and mobility Prevent inappropriate institutionalization Satisfy clients Improve quality of life Reduce public costs
Identify indicators of quality	Based on goals and outcomes identified, what indicators of program implementation or performance can be identified and what additional information is needed to properly interpret these indicators?	Structure indicators Caseload per worker per day Staff certification level Staff knowledge Staff turnover at customer level Process indicators Frequency of supervision Time between service request and provision Appropriateness of care plan Availability and frequency of informal care Outcome indicators Functioning Change in ADL and IADL status Safety Falls, Burns Health Infections, System distress Weight loss or gain Client Satisfaction Client perception of unmet need Quality of service Freedom from fear Comfort
Establish review of system and implement feedback	What processes are used for periodic or on-going review of quality indicators How are review findings used to correct or prevent problems? How shall assurance activities be reported to the public?	Presence of a quality assurance and improvement plan Checks on implementation of plan Evidence of enhanced achievement of desired goals and outcomes

Source: GAO Report # GAO/PEMD-94-19, *Long-Term Care*, Status *of Quality Assurance and Measurement in home and community-based Services*, March 1994

APPENDIX I
OTHER STATE INFORMATION

Other State Information

States have employed a variety of strategies to increase access to long-term care services, develop a wider range of options for frail elderly who need assistance with daily living, and control long-term institutional costs. Although states have designed their own programs to best meet the needs of their population, there are certain components common to all states. Many states have:

- limited the growth of nursing home beds through a certificate of need process, moratoria on construction, and restrictions on rates;
- expanded home and community-based services through both federal and state funded programs; and
- promoted the creation of supportive housing arrangements.

While Connecticut's long-term care system appears to contain most of these components, it is not considered a leader in supporting a home and community-based system (HCBS) of services. Despite the potential for savings, as well as the preferences of the elderly for home and community-based care, the majority of long-term care dollars in Connecticut are spent on institutional care.

A recent study, sponsored by the U.S. Administration on Aging measured each states' (and the District of Columbia's) progress toward developing a HCBS.[1] The study used a variety of indicators to evaluate each state including: demographics; nursing home utilization, supply, and expenditures; home and community-based expenditures; and total long-term care expenditures. Table I-1 through I-3 presents information on how Connecticut fares relative to other states in supporting a strong HCBS.

Table I-1 presents the results of the study and ranks (number one being the best) the top and bottom five states (and the District of Columbia) in terms of progress achieved. Connecticut received a below average rating, ranking 49th in the nation overall, with only North Dakota and the District of Columbia placing lower. To develop this measure, the study examined states' control of nursing home utilization and expenditures, the potential demand on the public long-term care system, and the level of commitment a state had in establishing home and community-based services. States that earned high ranks tended to devote a large share of their total long-term care expenditures to home and community-based services.

Other New England states also did not receive high ratings under this study. Massachusetts and Maine both were assigned an average rating and were tied for a rank of 32nd in evaluating their progress toward a HCBS. In addition, Vermont and New Hampshire received a below average rating, ranking 37 and 40 respectively.

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[1]National LTC Mentoring Program, Institute for Health Services Research, School of Public Health, University of Minnesota, *State LTC Profiles Report*, November 1995.

Table I-1. Progress and Commitment Toward a Home and Community-Based System: Top Five and Bottom Five States (1992).	
Rank (Progress)	***State***
1	New York
2	Oregon
3	California
4	Washington
5	Texas
46	Louisiana
47	Ohio
48	Rhode Island
49	Connecticut
50	North Dakota
51	District of Columbia

Source: National LTC Mentoring Program, Institute for Health Services Research, School of Public Health, University of Minnesota, *State LTC Profiles Report*, November, 1995.

Table I-2 ranks states based on the percentage of total long-term care expenditures dedicated to home and community-based services. Medicaid nursing home expenditures as a percentage of total expenditures is also shown in the table. A comparison of long-term care expenditures within the Northeast region shows that Connecticut still ranks near the bottom (40th) in terms of the percentage of total long-term care expenditures used for providing home and community-based services.

Furthermore, using the measure of Medicaid nursing home expenditures as a percentage of all long-term care expenditures, the New England states again did not fare well. Medicaid nursing home expenditures for the New England states, ranged from 93.8 percent of total long-term care expenditures in Rhode Island to 87.3 percent in Massachusetts, still significantly higher than the U.S. average of 78.7 percent.

Table I-2. Northeastern States: LTC Expenditures (1992).			
Rank	*State*	*HCBS Expenditures as a % of all LTC Expenditures*	*Medicaid NH Expenditures as a % of all LTC Expenditures*
2	NY	43.4%	56.6%
22	NJ	13.3%	86.7%
25	MA	12.7%	87.3%
26	ME	12.6%	87.4%
39	NH	9.3%	90.7%
40	CT	9.2%	90.8%
41	VT	8.7%	91.3%
47	RI	6.2%	93.8%
Range:			
1	OR	50.4%	49.6%
51	MI	4.4%	95.6%
	U.S. Average	21.0%	78.7%

Source: National LTC Mentoring Program, Institute for Health Services Research, School of Public Health, University of Minnesota, *State LTC Profiles Report*, November, 1995.

Another measure that is used in examining a states' long-term care delivery system is the number of nursing home beds available per 1,000 people. Table I-3 provides the number of beds per 1,000 for two age groups -- aged 65 and older; and aged 85 and older. With the exception of Rhode Island, Connecticut has the highest number of beds per 1,000 for both age groups . New Jersey and New York had the lowest rate for both age groups, and were well below the national average.

All six New England states were above the U.S. average of 53.1 for beds per 1,000 for aged 65 and older and four New England states were above the national average for beds per 1000 for aged 85 and older.

Table I-3. Nursing Home Beds: 1992 Northeast States		
State	*Nursing Facility beds/1000 people 65+ (1993)*	*Nursing Facility beds/1000 people 85+ (1993)*
CT	65.9	592.8
MA	63.3	527.7
ME	60.9	507.8
NH	53.2	458.8
NJ	41.9	415.7
NY	44.7	382.2
RI	66.8	608.7
VT	53.6	437.5
U.S. Average	53.1	501.7

Source: Health Care Financing Administration, Extramural Report, *State Data Book on Long-Term Care Program and Market Characteristics,* August 1995.